

UNITED STATES OF AMERICA

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DEPARTMENT OF DEFENSE

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ARMED FORCES EPIDEMIOLOGIC BOARD

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MEETING

+ + + + +

WEDNESDAY

SEPTEMBER 13, 2000

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The Board met at 7:45 a.m. in the Executive Board Room of Walter Reed Army Institute of Research, 503 Robert Grant Avenue, Silver Spring, Maryland, Dr. F. Marc LaForce, President, presiding.

PRESENT:

DR. LAFORCE	President
DR. ALEXANDER	Member
DR. ATKINS	Member
DR. BERG	Member
DR. GARDNER	Member
DR. HAYWOOD	Member
DR. LANDRIGAN	Member
DR. MUSIC	Member
DR. OSTROFF	Member
DR. SOKAS	Member
COL. DINIEGA	Executive Secretary

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PREVENTIVE MEDICINE OFFICERS:

MAJ BALOUGH
CDR LUDWIG
LTC RIDDLE
CAPT SCHOR
COL WITHERS

AFEB LIAISON:

LTC NEVILLE
DR. WOODWARD

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P-R-O-C-E-E-D-I-N-G-S

(7:55 a.m.)

DR. LAFORCE: Let's get started. We will begin with some administrative remarks from Ben.

COL. DINIEGA: Okay. Good morning and welcome to the second day. Board members, don't forget your travel settlement. Fill that in when you get back home. Send it in and I'll review it.

Remember, you need receipts for anything over \$75.00, I think -- other than your airline ticket.

So if your taxi costs over \$75.00, you need a receipt on a single trip. Don't add them all up.

There has been a couple that have submitted over \$100.00 taxi bills. Your calendars for non-available dates -- we'd like to have the next meeting in the February time frame.

Colonel Neville, when you see Dana, the group that got together would really like Hickam to be considered. Hickam Air Force Base -- since the Air Force is going to host, they really would like it. I didn't twist their arms. I had nothing to do with that. Sign-in sheets, outside. You have to sign in for each day so we know who was here.

On the agenda, we have three briefings.

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1 One is an overview of WRAIR Preventive Medicine.
2 Personally, I would like to say that WRAIR
3 Preventive Medicine and the Board has had a
4 historical, longstanding association. And Dick
5 Miller, who now runs the Medical Follow-up Agency,
6 when I used to work for him in the mid-1980's and
7 Colonel Ernie Takafukia used to be there too and at
8 one time Linda was there, we used to regularly host
9 the meetings on behalf of the WRAIR Command in the
10 old War Room. And what a fabulous place and
11 historical place, with many, many tough decisions
12 and recommendations being made.

13 And since then, the Division of
14 Preventive Medicine and Preventive Medicine in the
15 Army has really changed. So we will hear what the
16 Division of Preventive Medicine is about this
17 morning.

18 And then Dr. Dale Smith, who I think
19 isn't here yet, will give the talk on DNBI during
20 the Korean War.

21 And then Dr. Woodward -- and the
22 question was raised to me, did he maybe go to the
23 old WRAIR. And I said, maybe, but we did send him
24 maps to the new WRAIR. And I am not too sure that
25 Dr. LaForce mentioned it is at the new WRAIR when

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1 you talked to him.

2 DR. LAFORCE: But I knew we were sending
3 a map.

4 COL. DINIEGA: Oh, we sent a map and a
5 formal letter of invite. So I think he will
6 eventually get here. And then we are due for
7 subcommittee members. And with this many members, I
8 will leave it up to Dr. LaForce whether or not you
9 need to split up. We have the next two rooms out
10 here. And it may be that people want to get
11 together for a little bit and then come back and
12 discuss all the issues together anyway.

13 Colonel Crumrine was very busy yesterday
14 and didn't have much flexibility in his schedule
15 for tours. But he is willing to give building
16 tours, 15 to 20 minutes, for small groups any time
17 that we want it. So, first, is there anybody in
18 the room who wants to go on a tour of the new
19 WRAIR? One, two, three, four, five, six. Okay, we
20 can do that. We are going to go into Executive
21 Session whenever the subcommittees are done with
22 the work -- we will go to Executive Session. We can
23 do it at that time or at the very end after it is
24 all over. Or we can do it after the last talk and
25 before we go into subcommittee. Whatever you think.

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1 I would think that --

2 DR. LAFORCE: I would propose that we
3 probably not break up into subcommittees. We are
4 really quite -- I mean, the groups is really quite
5 small -- especially with Rosie not being here. And
6 I would think that we should just simply stay
7 together and go through the agenda.

8 COL. DINIEGA: And then to the end.

9 DR. LAFORCE: You bet.

10 COL. DINIEGA: And then do the tour at
11 the end?

12 DR. LAFORCE: You bet.

13 COL. DINIEGA: I would say time will
14 permit. So, okay, we will do the tour again. Is
15 that good for everybody? Okay. So you have --

16 DR. LAFORCE: Yes, I have got a couple
17 of things that I need to talk about.

18 COL. DINIEGA: Okay.

19 DR. LAFORCE: There is an administrative
20 problem that has arisen that has to do with Stan
21 Music and Ted Tsai. It is my sad duty to say that
22 this will be Stan Music's last meeting with the
23 AFEB. There has been, over the last I guess two or
24 three months a request from a pharmaceutical
25 company that I will not mention -- with the request

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1 that because Stan has a position with a
2 pharmaceutical company at the present time and so
3 does Ted, that there was a supposition that all
4 pharmaceutical companies should have representation
5 at the AFEB. We tried to point out that Stan's
6 appointment and Ted's appointment to the Board long
7 anti-dated any relationship that either had with
8 pharmaceutical companies. Nonetheless, it was the
9 -- I would say -- decision by legal staff advising
10 the AFEB that the AFEB follow what is called an
11 all-or-none rule. And the all-or-none rule is that
12 no individual serve on the Board with formal
13 relationships with a pharmaceutical company or all
14 would participate in some way, shape or fashion.

15 So with that rather grim alternative in
16 mind, both Stan and Ted will resign from the Board.

17 And Stan has asked to say a few words to the
18 Board. Stan?

19 DR. MUSIC: This is a little awkward
20 because this has been a great pleasure and I have
21 enjoyed working with a lot of people. Marc, you
22 are exactly right, I was Chief of Occupational and
23 Environmental Epidemiology for North Carolina when
24 I was appointed to the Board, and I stayed with
25 that and stayed away from vaccine issues and

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1 vaccine policy. No one at Merck asked me for a
2 report and nobody knew what I did and when I was
3 doing AFEB business, it was on my own and I am very
4 proud of what we have been able to accomplish and
5 grateful for the collegiality and the advances we
6 have made.

7 But I understand the situation and there
8 is nothing that anybody is going to be able to do
9 about it. Thinking about this Board and how it
10 functions, and we will hear from my old professor
11 of medicine at Maryland, Ted Woodward, later about
12 the Board and his perspective.

13 The Board has been reconfigured to the
14 point where it is very different from its original
15 configuration, where it had commissions that had
16 lots of money and that funded a great deal of
17 seminal research in many areas. We are now purely
18 advisory.

19 But when I compare this Board and its
20 function and how its advisory notices or
21 recommendations are made public to another advisory
22 board with which I am also an also a provider, the
23 Advisory Committee on Immunization Practices to CDC
24 and the Public Health Service, I find some things
25 there that I would just bring to your attention

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1 because I think they are meritorious. Not
2 necessarily to be directly or completely emulated,
3 but they have some bells and whistles that I think
4 we would benefit from.

5 The Advisory Committee for Immunization
6 Practices is appointed by the Secretary of Health
7 and Human Services and there is a formal venting
8 process. And the debates are spent on ideas.
9 There is a lot of principle and discussion that
10 goes around and very little real wordsmithing. The
11 wordsmithing that is done after they pass a
12 resolution is done in a committee with staff from
13 CDC from the relevant part of the Public Health
14 Service and a subcommittee from the Board itself.
15 So that the final recommendations are crafted
16 thoughtfully with lots of time and none of the
17 press of an existing meeting and people waiting to
18 get on airplanes.

19 The advisory nature is one that is taken
20 seriously, but none of the advice that the ACIP
21 gives to the Public Health Service is accepted
22 until it is formally published as a supplement to
23 the MMWR, and then those words that have been
24 carefully wordsmithed and agreed upon are the
25 official recommendation. If a recommendation falls

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1 short and the Public Health Service sees it doesn't
2 want to do it, nothing happens. There is no
3 publication. The recommendation is on the public
4 record as part of a public meeting, but there is no
5 publication. And there is none of the problems that
6 we seem to have in this Board of revisiting an
7 issue and going on the record time and time again,
8 only to have what apparently is our advice falling
9 on somewhat deaf ears.

10 I think that this mechanism or some
11 variation of it is something that would give this
12 Board a lot more visibility. Maybe having the
13 recommendations published in Military Medicine or
14 in some other official journal would be very
15 useful, and I think the idea of having these
16 recommendations get a lot wider circulation than
17 they currently do in the form of a memo that is
18 signed by a two or three star is probably more
19 beneficial in the long run and would make
20 recruiting for this Board as well as the advice
21 that the Board gives much more visible to the
22 medical pieces of DoD than is currently present.

23 That is really all I wanted to say
24 because I think the work of this Board is very
25 important and I have worked hard with lots of good

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1 colleagues whom I will miss. And I want to leave
2 this advice or thoughts with you because I think it
3 may be useful to you. And I want to thank
4 everybody.

5 DR. LAFORCE: What I forgot to mention
6 also for those of you that remember, Stan led the
7 Board review of the squalene issue, which was
8 handled very deftly. And the Board wants to thank
9 you for not only the advice --

10 DR. MUSIC: I had a lot of help.

11 DR. LAFORCE: Well, Elizabeth, sure a
12 lot of help. But there has to be somebody who leads
13 it. Yes?

14 DR. ALEXANDER: I think there are two
15 issues that you bring up that merit discussion and
16 they are really separate. One is the industry
17 issue and the other is what can we do to be more
18 efficacious as a Board. I am not sure which one to
19 deal with first.

20 The industry issue has me troubled for a
21 number of reasons. At the macro level, when we
22 think about the issues that this Board must
23 address, the solutions lie in industry. Whether it
24 is something that DoD goes out and develops in
25 terms of its own technology and its interface with

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1 industry, or whether the answer, whether it is a
2 diagnostic, a therapeutic or a vaccine -- the
3 answer or the solution for these infectious issues
4 really lies with technology. And so to divorce
5 ourselves and to put fire walls between us and
6 industry to me represents very myopic thinking.

7 Now I know that we have to be careful to
8 avoid any appearance of impropriety and to avoid
9 any appearance of wrongful influence. On the other
10 hand, I work closely with industry. I have learned
11 that as a non-profit organization that there are
12 ways to work with industry that are non-branded and
13 that are non-contaminated. When you look at the
14 Venn diagram of interest that we share common
15 denominator issues and opportunities and that by
16 working in partnership with industry in a way that
17 doesn't promote a particular product multiple
18 interests can be served. And I think that is true
19 for the military as well. It certainly works for
20 CDC and NIH. We do so with great caution, great
21 trepidation. We insulate things very carefully.
22 Nonetheless, we have very strong partnerships with
23 our federal agencies and our industry
24 representatives.

25 Next week, in fact, Joel and Kelley will

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1 be there. We have a partnership with the seven
2 pharmaceutical giants, one of which is Merck, where
3 we are coming together to work on shared interest
4 about STDs. We have to educate the public. We have
5 to educate providers. We have to help policy
6 makers understand the issues with reimbursement
7 issues. We have to ensure access and equality of
8 care for all people who are infected. These are
9 shared interests. They are not brand specific. It
10 is not a particular drug. It is not a particular
11 diagnostic. But together, working as a team, we
12 can serve a public health mission.

13 So I am really concerned about what is
14 happening to you, Stan. I don't feel comfortable
15 with it because I think it thwarts the very
16 activity that this group is trying to do to seek
17 resolution to problems. I don't know if I am out in
18 left field. That I have just become a civilian and
19 I have lost my military bearings. But it just
20 doesn't feel right to me that we as a group, the
21 AFEB, can't have some relationship with industry.
22 I don't understand that.

23 COL. DINIEGA: I think there is still an
24 open relationship with industry in that for example
25 yesterday we had several pharmaceutical

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1 representatives and they routinely try to come to
2 the meetings. It is an open meeting. So their
3 presence at the meeting is not an issue. The issue
4 was being a member of the Board, which happened by
5 happenstance because people moved on to different
6 jobs.

7 DR. GARDNER: Ben, just to follow Stan's
8 line of the analogy. One of the very interesting
9 and I think helpful things that the ACIP does is it
10 has its group of voting members. But then it has
11 another group, equally large -- actually perhaps
12 even a little larger -- of liaison members,
13 including a group representing -- there is a
14 pharmaceutical organization and they have a
15 designated hitter who represents industry issues in
16 general and that rotates among different industry
17 leaders. There is other groups -- I know Pete
18 Patrick is --

19 DR. MUSIC: These are resources for the
20 ACIP, but they are not voting members.

21 DR. GARDNER: That is right. So one
22 could consider -- I mean a way to have industry
23 input and collegiality would be to have a set of
24 formal liaison members to our Board that would
25 represent -- that would ensure that. And it would

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1 make things up front too and specific.

2 COL. DINIEGA: That could be done too.

3 But you know each of the pharmaceutical companies
4 have somebody who is in charge of military or do
5 the affairs and interest for marketing. And they
6 routinely -- they can attest to it -- they
7 routinely stop by to see the Executive Secretary
8 and also the preventive medicine officers and each
9 of the surgeons. And those are the people that I
10 say avail themselves of the meeting on a regular
11 basis.

12 DR. MUSIC: I am sure it works but --

13 COL. DINIEGA: And then to formally --
14 you see, one of the options was to formalize
15 pharmaceutical recommendations of the Board and the
16 discussion floated to the major pharmaceutical
17 companies. We also have all the little tiny ones,
18 and the question is how do you leave out anybody.

19 DR. MUSIC: With all due respect, Ben,
20 the pharmaceutical representatives are on the sales
21 and marketing side. They are not at the policy
22 level and they are not at the science level and we
23 need to be aware of that distinction. And I would
24 say that the whole federal government is still
25 struggling with this.

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1 I will just leave you with a quick
2 anecdote. I was notified yesterday that at 2:00
3 there was a telephone conference between my boss at
4 Merck and somebody in CBER in the FDA, where CBER
5 was telling us what was going to appear in today's
6 JAMA, which is their analysis of the last five
7 years of data on our varicella vaccine. We have
8 the only licensed varicella vaccine, and they are
9 publishing an analysis without even a courtesy to
10 tell us what they have discovered prior to it going
11 into print, which makes no sense and makes a
12 mockery of collegiality. So we are still struggling
13 with this on many fronts.

14 DR. LAFORCE: I would propose that --
15 let's come back to this in Executive Session and
16 move on to the agenda items. The first speaker this
17 morning is Major Pavlin for Colonel Kelley to
18 describe the WRAIR briefing. Good morning.

19 MAJ PAVLIN: Good morning. Good to see
20 all of you again. Welcome again to Walter Reed
21 Institute of Research. You know who I am, and I am
22 filling in for Colonel Kelley. He says in his
23 little notes here that he is in Indonesia this
24 week. The truth is, yes, he is in Indonesia. He is
25 in Bali this week, and I offered to change places

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1 with him, but he wasn't taking me up on that offer.

2 So here I am.

3 UNIDENTIFIED SPEAKER: We are jealous.

4 MAJ PAVLIN: I know. I know. A whole
5 week in Bali. And then I think he has got to go
6 off to the Caribbean a few times later this month
7 and he just got back from the Caribbean. So it is
8 that end of the fiscal year travel cycle, use it
9 all up before September 30. So he is gone for about
10 a month.

11 So he wanted -- he wrote down a few
12 notes for me, so I will follow along with those.
13 And you have in your handout some of his slides.
14 The Division of Preventive Medicine has a long
15 history of contributions to the Army, and the most
16 significant being that more than half of all
17 current Army preventive medicines have been trained
18 here in their residency program. That not only
19 includes Army, but beginning in 1980 Navy and Air
20 Force. Some of their key preventive medicine
21 leaders have been trained here, and that includes
22 the current Navy PM consultant. I didn't see
23 Captain Gray. I guess he didn't come yesterday?

24 DR. LAFORCE: He was here in the
25 morning.

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1 MAJ PAVLIN: He was here. He also
2 trained here at Walter Reed. And now our Coast
3 Guard preventive medicine consultant is also a
4 graduate of the Walter Reed Program. So we have
5 managed to get our tentacles in a lot of different
6 places.

7 Virtually all the preventive medicine
8 officers that have ever served at the overseas labs
9 also have trained here. So it is a source for that.

10 So obviously we need a good strong base here to
11 maintain that.

12 Next slide please. Because of that
13 residency training, we really take our mission very
14 seriously here. This is the mission statement and
15 it is in your notes. And it emphasizes the fact
16 that we are not only an asset to the Army, but we
17 have programs that benefit the entire DoD. And with
18 respect to the presidential mandate on emerging
19 infections, which I will talk about a little bit
20 later, we have a real formal role to fill on a
21 unique national lead.

22 The staff here -- Colonel Kelley has
23 been able to get some very good people here on his
24 staff to assist in the residency training. On his
25 staff are three former residency directors. So

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1 their experience totals 25 years in directing the
2 residency programs -- different residency programs.

3 Colonel Prados was the residency director at
4 Madigan. Colonel Gaydos, I believe you must be the
5 other person he is referring to as residency
6 director. You did that for some time. And Colonel
7 Kelley himself was a residency director here. So
8 they have a lot of achievements. He also noted that
9 Dr. Gaydos had received the prestigious Malone
10 Award for outstanding military academic leadership.
11 So our people are well represented.

12 The next slide, please. We have been
13 able to establish a broad base of support over the
14 last few years. We all know that money is tight. So
15 we work with a lot of different organizations. You
16 probably know when CHPPM stood up about four years
17 ago, a lot of our operational medicine assets and
18 missions went over to the CHPPM, but the residency
19 could not leave because they didn't have some of
20 the operational base to keep that accredited if it
21 was moved to the CHPPM. So the residency stayed
22 here, but a lot of the assets went to CHPPM. So it
23 was a little bit of a tough time. But I think that
24 the training base now has stabilized and this past
25 year WRAIR residency was able to get a flawless

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1 reaccreditation when the ROC had put over 40
2 percent of the civilian preventive medicine
3 programs on probation. This went through with no
4 even recommendation for change at all. So fully
5 accredited for five years.

6 Next slide please. Take a close look at
7 this one. I realized going through the notes this
8 morning that he didn't update some of those people.

9 So Lieutenant Colonel Dave Niebuhr is here now and
10 on some of the other slides it says it is vacant.
11 And the CHPPM detachment for the residency. These
12 are the residency and assistant residency directors
13 that are currently here now. So remember this
14 slide.

15 There is three functional areas under
16 the Office of the Director for the Division of
17 Preventive Medicine. Colonel Kelley not only is
18 the director, but he also has some special projects
19 he is working on. One which should be coming to a
20 close at the end of this year is he is the
21 specialty editor for the Bordon Institutes Textbook
22 of Military Medicine Volume entitled Preventive
23 Medicine, Mobilization and Deployment. And this
24 textbook features over 120 authors with over 150
25 reviewers. So it is going to be a two volume --

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1 the first two volume textbook of military medicine
2 coming out. Hopefully we will see this on the
3 street next year. It has got seven major sections.

4 It covers preventive medicine history,
5 mobilization and training, predeployment, post-
6 deployment and deployment issues in operations
7 other than war. It is over 90 percent complete
8 now. So it has been a big work.

9 He also is the director of the DoD
10 Global Emerging Infection System, and that is why
11 he is in Indonesia. There is a meeting there to do
12 some regional surveillance efforts through PACOM.

13 Next slide, please. The Department of
14 Field Studies is what I am chief of, and I also
15 serve -- mostly I work with the DoD Global Emerging
16 Infections Program, since the missions of those two
17 overlap quite a bit. I don't -- you see I am the
18 only person there. That is me. I have nobody else.
19 So I don't have a lot of support staff to work
20 with. I work on different issues with virus
21 surveillance you heard about yesterday, some of the
22 bioterrorism and rapid surveillance efforts you
23 heard about yesterday.

24 Here is some more background on GEIS.
25 Go ahead, next slide. GEIS was -- now how many

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1 people have heard about GEIS? You probably got a
2 briefing before. Okay. So you've got that. You have
3 got the annual reports, I won't read all this. But
4 it was started up in 1996 as a Presidential
5 Decision Directive to work with emerging infection
6 surveillance and to increase a lot of our defenses
7 recommended after the Institute of Medicine study
8 that we really need to promote and preserve some of
9 these DoD overseas assets, including the five
10 overseas labs.

11 Next slide. This is the -- kind of the
12 abridged version of how we got here. You can read
13 through that. We do have an oversight board that
14 is chaired at the DoD health affairs level with
15 flag representation from each of the Services, from
16 DDRNE and the Joint Staff.

17 Next slide. This is our budget for GEIS.
18 We are funded from the Defense Health Program in
19 P8 dollars. As you know, the Defense Health
20 Program is very short with tri-care issues. So it
21 is significant that they have given us this much.
22 We have gotten a total of about \$54 million through
23 fiscal year 2005. But most of this, we are
24 directed to spend at least 65 percent of this in
25 support of the five Army and Navy overseas

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1 laboratories. So most of that goes directly to
2 those overseas labs as you can see.

3 We do kind of leverage this as much as
4 we can with other funds. Colonel Kelley has been
5 able to receive over \$400,000 from South COM to do
6 a humanitarian assistance project down in the
7 Caribbean.

8 Next slide. This is our functional
9 chart. Dr. Gaydos, that is you and that is me.
10 Just remember that. The organization here -- it is
11 constantly in a flux. But this is the current one.

12 Captain Davis assists Colonel Kelley with the
13 Deputy Director job there and works with him on
14 developing a lot of -- especially on the CONUS
15 aspects of what we do in GEIS. Mr. Jim Writer, who
16 I share an office with, works as Director of
17 Training and External Relations, mostly with
18 respect to the CINCS and some of their engagement
19 exercises that we are trying to work with them.

20 Colonel Kelley also serves as the co-
21 chairman, I believe with Dr. Ostroff with the
22 subcommittee of the task force on the Office of
23 Science and Technology policy. So he works on that
24 level. And we have some major partners that
25 include the CDC, the State Department, NASA, NOAA,

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1 USAID and the FDA.

2 Next slide. I don't have much time to
3 go into all the different GEIS projects, but they
4 are summarized here. You should have all gotten
5 one of the strategic plans or at least one of the
6 annual reports I have seen float around so you have
7 an idea of what is going on there. Dr. Phil
8 Brockman of Emory University is now chairing an
9 Institute of Medicine review of all the overseas
10 laboratory programs and the CONUS programs. So we
11 will be getting the results of that within a year.

12 Next slide. That is fine. The
13 Department of Epidemiology is headed by Colonel
14 Krauss. The primary center -- what they do here in
15 the Department of Epidemiology -- and again, she is
16 now assisted by Colonel Dave Niebuhr, who has just
17 arrived -- is the AMSARA, which is the Accession
18 Medical Standards Analysis on Research Activity.
19 This was established about two-and-a-half years ago
20 to provide evidential basis for accession
21 standards. It has a whole list of names here. The
22 working group responds to the Accession Medical
23 Standards Steering Committee which is co-chaired by
24 the Deputy Assistant Secretary of Defense for
25 Military Personnel Policy and the Deputy Assistant

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1 Secretary of Defense for Clinical Program Review.
2 We know that about 35 percent or so of recruits
3 that come in have premature attrition. And with
4 the high healthcare costs associated with that of
5 training and also treating them if they have
6 preexisting medical conditions is seen by the GAO
7 as being very important. The P8 funding for this
8 department is about \$525,000.00, and most of that
9 is used to support our in-house contractor staff.
10 Tim Powers is in the back there if you have any
11 questions on AMSARA. He is here. He is one of our
12 contractors on that program.

13 Next slide. These are the objectives of
14 AMSARA. For example, to validate current and
15 proposed standards such as should flat feet -- and
16 I believe they have determined no that flat feet
17 should not be disqualifying. These are things that
18 are historical that have just been there forever
19 that this is a disqualifier. So they have changed
20 that. To validate assessment techniques and to
21 determine that the current screening tools that are
22 currently in use actually have a good predictive
23 value. And also to do some quality assurance to
24 make sure that, for example, some of the MEPS
25 stations -- the military entrance processing

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1 stations -- might vary in the frequency of
2 diagnosing certain types of conditions, but then
3 the level of attrition from these different areas
4 isn't any different. So we notice they are missing
5 some of these, but yet it is not seeming to affect
6 what soldiers drop out or what ones don't. So that
7 is important as well. And the bottom line is to
8 impact and recommend changes to any policy if they
9 should so-warrant. And I believe they have already
10 done that in quite a few instances.

11 Next slide. There is a whole bunch of
12 information that I certainly won't go through right
13 now. But in the back we have a box of these -- Tim
14 has got them there. It is over to the other side,
15 Colonel Diniega. If anybody is interested, this is
16 one of the annual reports from 1999. They go
17 through much of what they have found and you are
18 welcome to take one of those with you.

19 Colonel Krauss also has a lot of other
20 activities in her department including an NCI
21 funded program project grant with Harvard and Johns
22 Hopkins to study serologic precursors in military
23 populations for Hodgkin's disease. And also an
24 analysis of Hepatitis C screening in the military
25 as well as assisting with many of the residency

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1 projects. She is also working on a rapid, simple
2 and cheap dipstick assay for measles, mumps and
3 rubella. So hopefully we can stop immunizing people
4 that are already immune and we can save some money
5 on that.

6 Next slide. And last, again this is
7 Colonel Lisa Keep. Lieutenant Colonel Lisa Keep is
8 now the Residency Director assisted by Major Bob
9 Mott. They are actually assigned to CHPPM as well.

10 They have an instruction system specialist and a
11 secretary, but they are located here in his
12 building. The residency, again as I have said, has
13 been fully accredited for five years. Currently
14 there are four Army residents. They are in the
15 back corner there of the room, plus one recently
16 graduated resident, as well as one Navy resident
17 who is not here right now. The residency brochure
18 I believe is in the back of the room and you are
19 welcome to pick up copies of those.

20 Next slide. Major Bob Mott, who I
21 mentioned, is also the Deputy Residency Director.
22 He also co-directs the Military Tropical Medicine
23 Course and the Army Force Protection Conference. So
24 he keeps very busy.

25 To assist in the audience, Dr. Gaydos

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1 knows a lot about especially the military health
2 side of the DoD GEIS program and Tim Powers from
3 AMSARA. So if you have any questions, feel free to
4 ask any of us. That concludes my briefing. Any
5 questions?

6 DR. LAFORCE: Thank you. Questions?
7 May I ask what the budget is?

8 MAJ PAVLIN: I don't know. I am not
9 privy to that information. I really don't. Dr.
10 Gaydos, do you know?

11 DR. LAFORCE: I am sorry I asked.

12 DR. GAYDOS: I think we are running
13 about \$10 million or \$11 million right now.

14 DR. LAFORCE: For GEIS.

15 DR. GAYDOS: For GEIS.

16 MAJ PAVLIN: Oh, for GEIS. I am sorry,
17 for GEIS.

18 DR. LAFORCE: Yes, that is what I meant.

19 MAJ PAVLIN: For GEIS it is -- is it
20 that much? \$8 million?

21 DR. GAYDOS: We are on a ramp and I
22 think right now we are about \$10 million.

23 MAJ PAVLIN: It goes up about a million
24 a year. I thought it was more like \$8 million.
25 Where is that slide?

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1 DR. LAFORCE: I just noticed you had it
2 on one of the slides.

3 MAJ PAVLIN: Yes, it was about \$7
4 million this year.

5 DR. GAYDOS: It is about \$8 million.

6 MAJ PAVLIN: Yes, we are expecting \$8
7 million for next fiscal year.

8 DR. LAFORCE: Other questions for Major
9 Pavlin?

10 COL. DINIEGA: I just want to make a
11 comment. As far as physician training in preventive
12 medicine and occupational medicine, there are other
13 places that do training. USU, the Uniformed
14 Services, has a preventive medicine residency
15 program and an occupational medicine residency
16 program. And that is where the old Army
17 occupational medicine program was moved to. It is
18 now all at USU. And then the Air Force runs an
19 aerospace medicine program, which is I think bi-
20 service. The Army avails themselves of the
21 residency as well as the Air Force. And I think the
22 Navy go somewhere else. But those are some of the
23 other training programs. And each of the Services
24 has their own preventive medicine agency per se.
25 The CHPPM being the one for the Army, whatever the

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1 name of the week is for the Air Force --
2 AERA/OPHSA, the Office of Prevention Health
3 Services Assessment -- and then the Navy is NEHC,
4 Navy Environmental Health Centers.

5 DR. LAFORCE: All right. Thank you.
6 Let's go on to the next presentation, Dr. Smith,
7 disease and non-battle injuries during the Korean
8 War. Dr. Smith is the Chair of Military History at
9 USUHS. And also welcome to Dr. Woodward.

10 DR. SMITH: For some of you it will be
11 review. For some of you it will be memory. For
12 some of you it will be history. In 1945 in April,
13 the United States succeeded in creating an
14 international body called the United Nations to
15 assure that we would not have to go through the
16 trauma of war on a global scale another time.
17 There was a conference that winter in Yalta, where
18 the big three -- Churchill, Roosevelt and Stalin --
19 sketched out with a certain amount of ambiguity the
20 resolution of world affairs at the close of the
21 war.

22 The United States was at the same time
23 developing an atomic weapon which we would use on
24 the 8th of August and bring the war to a
25 conclusion. The Soviet Union entered the war

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1 against Japan on the 9th of August, moved into
2 Manchuria and Northern Korea. And in the
3 conclusion of the Second World War, the Korean
4 Peninsula was divided at the 38th parallel by a
5 Soviet zone of influence in the north and a U.S.
6 occupied zone in the south.

7 In 1946, the United States and the
8 Soviet Union negotiated a withdrawal from the
9 Korean Peninsula, and in Europe a variety of
10 Communist political movements in Western and
11 Eastern countries undertook to change the forms of
12 government in those countries.

13 The Communist parties in the west were
14 for the most part contained by democratic activity.

15 In Greece, there was a civil war. The British were
16 supporting the democratic element there and
17 couldn't afford it.

18 In 1947, President Truman issued the
19 Truman Doctrine that we would work to contain the
20 spread of Communism. We saw by 1947 the Communists
21 under the influence of the Soviet Union rapidly
22 spreading their, we thought, pernicious system to
23 the world.

24 In 1948, we would see further tensions
25 in Europe. Eastern countries would not have

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1 democratic elections. We would continue to withdraw
2 from the Korean Peninsula.

3 In 1949, we completed our withdrawal
4 from the Korean Peninsula in June. In the fall,
5 the Soviets exploded their atomic weapon and we
6 were in the midst of a growing period of tension.

7 From the Soviet point of view, their
8 leader and Defense Minister, Joseph Stalin, had
9 visited an American military cemetery in Murmansk.

10 He knew in his heart of hearts that Americans were
11 out to destroy the Soviet Union. He saw evidence of
12 this in the failure to open a Western front as
13 early as he thought the allies should have. And in
14 the post-war world, he set up a program of creating
15 a set of buffer states to prevent the Soviet Union
16 from being invaded again by a stronger economic and
17 military power.

18 In the Berlin Blockade, Truman let it be
19 known that atomic weapons were based in England
20 with the target of Leningrad and Moscow. Stalin
21 could not maintain the blockade against that
22 threat, but pushed harder to get his own weapon.
23 And in 1949, he did.

24 When this Cold War tension began to draw
25 lines, the United States Secretary of State in

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1 January of 1950 laid out American spheres of
2 influence where aggression by Communism would be
3 met with force if necessary. Unfortunately, his
4 line went through the Korean Strait. And
5 inadvertently, mostly because many people believed
6 he had never heard of Korea and didn't even know we
7 had had troops there six months earlier, Korea was
8 left out. The North Koreans, Communists and
9 Nationalists, negotiated with Stalin and with the
10 Chinese leader Mao Tse-tung to return to battle
11 tested Korean divisions that had been serving with
12 Mao and to get Soviet tanks. And in June, they
13 came south and overran the Republic of South Korea.

14 Let's move to the next slide. In a two-
15 pronged attack, taking Seoul and then coming down
16 the valley you see in the center, they pushed south
17 and American military assistance groups and
18 civilians fled.

19 The third slide, please. General
20 MacArthur, the proconsul for Japan, decided in
21 consultation with national command authority that
22 this invasion should be resisted. And so -- the
23 next slide -- he sent a task force of slightly
24 larger than regiment size on the assumption that
25 the simple sight of well-trained American troops

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1 would cause this Asian invasion, three corps in
2 strength, to turn back. General MacArthur was
3 capable of self-delusion. Task Force Smith
4 encountered the North Koreans and fell apart.

5 In part, they were overwhelmed and in
6 part they were simply outnumbered and in part they
7 were poorly prepared. We had drawn down our Army at
8 an exponential rate and there were not sufficient
9 forces in the area.

10 Next slide, please. We deployed
11 hospitals in support of this activity and other
12 troops would follow. The new MASH, a combination
13 of the Auxiliary Surgical Hospital of the European
14 Theater and the portable surgical hospital of the
15 South Pacific, provided support. Battalion
16 surgeons couldn't move the men to these hospitals,
17 as we fell back so fast we passed the chain of
18 evacuation.

19 Next slide, please. We were pushed back
20 into a parameter around Pusan -- next slide, please
21 -- and the Commander, General Walker, of the 8th
22 Army, had the privilege of giving an order seldom
23 given in American military annals. He ordered his
24 men to die in place. Such was the situation. The
25 Marines had two uncommitted divisions. They were

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1 both understrength by stripping out the second
2 division and adding it to the first division. They
3 were offered to MacArthur. The first battalions
4 went in to Pusan to strengthen the line -- next
5 slide please -- and the others invaded at Inchan.

6 In September, we broke out of the Pusan parameter -
7 - next slide -- moved north rapidly, the North
8 Koreans taken in the flank and rear as well as in
9 the front fell back. Next slide. We moved through
10 Seoul. Next slide. We began to move our medical
11 resources into country. We stripped out our
12 residencies and began to move -- next slide -- into
13 the north. And in this environment, we saw what
14 were classified as the first and most extreme of
15 our disease problems.

16 Next slide. Neuropsychiatric
17 causalities, which while not exactly unrelated to
18 battle were not wounds. And in the disasters of
19 the early months, not surprisingly there was a
20 phenomenal peak of neuropsychiatric causalities.
21 After September with Albert Glass's arrival and
22 division psychiatrists put in place, this began to
23 stabilize because the lessons were well known from
24 World War II.

25 Next slide, please. MacArthur continued

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1 to push north into North Korea. Next slide. As
2 winter began to come on, he entered into an area
3 that the Chinese had said they would defend. Next
4 slide, please. In late November, both wings of the
5 American advance were overwhelmed and went into, as
6 the Marine General Commanding said, attacking in a
7 different direction.

8 Next slide, please. In this retreat and
9 disaster, cold injury would create phenomenal
10 problems during that first winter. You will notice
11 the three winters compared on this slide. The
12 first winter where we had no gear, we had learned
13 the problems in 1945 and the Army Quartermaster,
14 quite frankly, was working very hard on developing
15 contracts to solve the problem. But as frequently
16 is the case, the system was overtaken by events.

17 Next slide, please. The line fought
18 back tenaciously in the South and began to
19 stabilize just south of Seoul. Next slide, please.

20 The problems of evacuation and surgical treatment
21 brought first efforts. Surgeons were deployed in a
22 consulting fashion. Next slide, please. General
23 Ridgeway ordered a stop -- next slide -- and an
24 attack back into the north. And a line not too
25 different from the original line began to stabilize

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1 by the spring of 1961.

2 Next slide, please. There were
3 phenomenal numbers of refugees. Next slide. The
4 sanitary conditions of the Korean people had not
5 been great before. Next slide. Our medical
6 resources, while stressed, now were beginning to
7 catch up. Next slide, please. We went into trench
8 warfare very similar to World War I -- fox holes
9 and trenches -- next slide -- but in a terrain that
10 was considerably more unforgiving.

11 Next slide. The situation through the
12 Korean War -- notice the initial assaults, the
13 removing to the North, and then occasional assaults
14 and negotiations of position along the trench lines
15 give you the humps of battle casualties. The
16 disease, while eventually coming down, will never
17 fall to the rate of battle casualties. The
18 casualties fall way down and seldom get above
19 disease. And non-battle injury, while coming up
20 occasionally with assaults, maintains a great
21 stability throughout the war.

22 Next slide, please. This situation of
23 altitude and cold and other environmental
24 situations gave rise to considerable non-battle
25 injury. Simply moving about in that kind of

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1 terrain was hazardous combined with the problems of
2 cold injury gave you a serious non-battle injury
3 potential, and one we had never much grappled with.

4 There had always been some concern with safety.
5 Nobody wanted anybody to get hurt, but training and
6 activity in the military is vigorous and quite
7 frankly there had always been disease problems as
8 there were in Korea, but considerably overwhelmed
9 the understanding of non-battle injury.

10 Next slide, please. The diseases were
11 about what you'd expect. Carded for record only
12 incidence of upper respiratory infections peaking
13 in the winter -- next slide please -- diarrheal
14 problems considerably greater than either the Far
15 East Command or the Army as a whole, reflecting
16 mostly contaminated water supplies and a certain
17 inattention to detail in mess arrangements -- not
18 unknown, really a problem for the non-commissioned
19 officers and a discipline rather than military
20 medical activity.

21 Next slide, please. As the war
22 stabilized, no one in military medicine was overly
23 surprised as the sexually transmitted disease rates
24 went up, not quite exponentially but almost. Next
25 slide, please. Malaria was known to be in parts of

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1 the Korean Peninsula, but not really much feared.
2 Some incidents in the first year, however, drew
3 attention to a problem as we adopted a new policy.

4 In 1951, following the Korean invasion, the draft
5 was reinstituted. And in this reinstitution of the
6 draft, concern about the Cold War Army began to
7 grow. And a decision was made to adopt a new
8 policy used by some other countries with gun boat
9 or small war activities in their past, usually
10 colonial, of rotation. A point system was put in
11 place, but essentially you stayed in theater a year
12 and then you could go home, however long the war
13 would last. As people on malaria suppressive drugs
14 went home and stopped taking their malaria
15 suppressive drugs, we relearned a lesson we had
16 learned after Guadalcanal and Fiji ten years
17 earlier that the failure to treat the malaria after
18 suppressive therapy will result in breakthrough.

19 Next slide, please. And the Surgeon's General and
20 the Armed Forces Epidemiology Board were called to
21 investigate.

22 Alf Alving of Chicago was put in charge
23 -- next slide, please -- of evaluating a series of
24 new drugs with contracts from the Army and a series
25 of suppressive and therapeutic agents were

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1 evaluated to monitor their impact on malaria in the
2 United States as a result of returning troops. And
3 as primaquine came on line and was tested, terminal
4 prophylaxis on ship was instituted as a result of
5 these studies.

6 Next slide, please. Other kinds of
7 problems that had been known before also occurred
8 in Korea. Hepatitis, particularly early in the
9 war, seemed to be epidemic. Again, food handling
10 seems to be implicated. Next slide. Then Captain
11 Thomas Chalmers -- next slide -- using the new
12 understandings of carefully controlled prospective
13 trials, designed a series of trials to evaluate
14 dietary change and rest to determine what was most
15 effective in allowing individuals to recover from
16 hepatitis.

17 Next slide, please. Chalmers, working
18 with this institution, then known as the Army
19 Medical Graduate School, in cooperation with people
20 in civilian institutions through the Armed Forces
21 Epidemiological Board, determined that you could
22 ambulate people much earlier than previously
23 thought, which in military medicine turned out to
24 be an important consideration and helped get
25 compliance with any regimen being used.

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1 Next slide, please. Colonel Francis
2 Pruitt, consultant in medicine and Chief of
3 Medicine at Walter Reed Army Medical Center,
4 reviewed the results of these activities after the
5 war, and he noted that there were two areas in
6 particular where the Army had had fears. They were
7 unable to do anything early in the war simply for
8 lack of trained resources. Pruitt noted that there
9 were 66 medical officers in Japan to deploy and it
10 took several months to strip people out of
11 residency. Even with one or two years of internal
12 medicine, they were more useful than people just
13 out of internship. And slowly, he said, data began
14 to be accumulated which could be trusted.

15 Next slide. It was well known that
16 there was a then thought to be arbovirus
17 encephalitis -- Japanese B encephalitis -- which in
18 the 1920's had devastated Japan with a series of
19 epidemics which was related to serologically and by
20 reaction studies in animals other viral diseases.
21 Remember, we are before Enders and culturing virus
22 is done in eggs if it is done at all -- next slide,
23 please -- and Japanese B encephalitis was predicted
24 in 1950 to be a problem. Dr. Albert Sabin had
25 worked on a killed vaccine during the Second World

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1 War and the Army Medical Graduate School had
2 refined that vaccine effort in the inter-war
3 period, and it had been given. It took three doses
4 separated over time by an interval they thought of
5 at least six months and preferably a year. And
6 nobody knew whether it worked.

7 As data began to come in, it became
8 clear to Colonel Pruitt that one of the things that
9 had happened was vaccine records had not been
10 sufficiently kept. And in many divisions, they did
11 not have any idea what percentage of the active
12 force may or may not have been vaccinated. The
13 24th and the 25th Infantry, for example, were at
14 least partially vaccinated, maybe as much as 40
15 percent, maybe as low as 20 percent. 60 percent of
16 the people could not be found to have any
17 vaccination immunization records at all. The
18 Marines were known to be for sure not immunized as
19 was the 27th British Brigade and the 5th Regimental
20 Combat Team. So at least some effort could be made
21 to evaluate retrospectively the impacts of
22 vaccination if -- and it was a big if -- the
23 vaccinated divisions had been vaccinated
24 successfully. Then they should have less Japanese
25 B encephalitis. The data were statistically

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1 ambiguous.

2 Next slide, please. The tactical
3 situation provided some partial opportunity to
4 evaluate. The unimmunized and the immunized seemed
5 to be randomly distributed around the Pusan
6 parameter. Many soldiers were kind of randomly
7 distributed around the Pusan parameter, and where
8 8th Army thought people were wasn't necessarily
9 even where they were. So this data, even though it
10 doesn't tell you anything for sure except that
11 being near rivers is probably worse for you than
12 not, is ambiguous itself.

13 Next slide, please. And so Pruitt and
14 his colleagues concluded that their data were at
15 best ambiguous. The best methods of control were
16 ineffective. They were mosquito control and that
17 is difficult to do in a war, particularly in a
18 retreat. The demonstrated conclusiveness of the
19 effectiveness of the immunization regimen was at
20 best a Scotch verdict of not proven. There was no
21 effective therapy demonstrated. But the problem
22 really didn't get as bad as they thought it would
23 and they quite frankly didn't know why. But they
24 were glad it hadn't. They discontinued the advice
25 of the Army Epidemiological Board -- excuse me,

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1 Armed Forces Epidemiological Board use of the
2 immunization and WRAIR was charged to build a
3 better vaccine.

4 Pruitt also noted there had been a
5 surprise. Next slide, please. Thought to be
6 leptospirosis initially, a new febrile disease
7 known in the Korean and some Russian literature, a
8 hemorrhagic fever with renal complications to
9 follow-on called creatively Korean hemorrhagic
10 fever, etiology unknown, epidemiology unknown,
11 outcome pretty lousy was noted. But it seemed to
12 taper out. Epidemiological work was undertaken.
13 Studies were begun. Data was collected. Tissue
14 was examined. Efforts were made. And at the
15 conclusion of the war, it remained a problem to be
16 solved, probably related to rodents, at least that
17 is what the Koreans had suggested.

18 Next slide. What is clear from the
19 experience is that the Army medical department was
20 not in any serious way prepared for ground combat.

21 This is not surprising. The Army was not
22 prepared. The doctrine was we had an atomic weapon,
23 there would be atomic wars, there would not be any
24 more wars. The Air Force wanted all the money for
25 new toys and people were not needed. Is it

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1 history? Yes, well, the problem was that it didn't
2 work out that way. And as the Army went to war,
3 Army medicine and Navy medicine and following
4 Marines struggled along. When the first Marine
5 division went in, only the division surgeon had had
6 World War II experience. It has only been five
7 years. The lessons of World War II are not
8 forgotten. This is not a question of lessons
9 learned. It is lessons known by the people who
10 needed to know them. The thing that we discovered
11 in Korea historically is that military rotational
12 policies mean that the people who learn the lessons
13 go on to other jobs. And so the new people who have
14 not learned the lessons and frequently are not
15 taught the lessons are discovering new things that
16 have been discovered many times before.

17 One of the new things that Pruitt
18 pointed out that they needed to discover and
19 institute a way to solve was to collect prospective
20 data from the beginning and keep up with things
21 like immunization status, so that you could
22 evaluate the data you had using the modern
23 biostatistical techniques. This was considered by
24 a variety of commissions and a variety of boards
25 and a variety of very bright people. We still don't

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1 have a very good way to collect data prospectively
2 from the beginning of a deployment. We are getting
3 a little better. But Pruitt had it two months into
4 things. Pruitt was concerned that nothing had been
5 done about cold injury. Nothing had been done to
6 ensure that neuropsychiatric causalities were
7 managed from the beginning. It took three months
8 for the consultants to get things up and running.
9 It took four months to get infectious disease
10 specialists, first from the United States and into
11 Japan and then to set up specialty hospitals in
12 Korea for the hemorrhagic patients and other kinds
13 of new problems.

14 And finally, since many of these
15 problems have been solved by immunization and since
16 in the late 1960's the Surgeon General of the
17 United States declared that infectious disease is
18 no longer a problem for American medicine, we have
19 begun to do a very good job of keeping soldiers
20 healthy from disease, much better than we did in
21 Korea. We have begun in recent years to do a
22 better job on accidents and non-battle injury. But
23 I would submit to you that just like Pruitt and
24 Alving and Chalmers had to take apart the disease
25 experience of Korea in order to relearn the

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1 military medical lessons and to learn new lessons
2 of medical science, we are now faced with a need to
3 take apart non-battle injury. To differentiate its
4 components into some sort of better nosography to
5 follow. We still need to learn the lessons of the
6 Korean War in real time prospective information. We
7 are better, but they thought they were so much
8 better than people had been in the past war too.
9 And one lesson to always remember as you deliberate
10 and as you advise, is that the people who will
11 implement what you suggest, do not have the
12 experience of the people who gave you the idea and
13 told you it was doable. To make it so it will work,
14 it has got to be soldier and sailor proof. Have a
15 good meeting.

16 DR. LAFORCE: Questions for Dr. Smith?

17 I have one. I was -- I didn't realize the extent
18 of cold injury, and I was quickly looking through
19 the rates. The rates during December/January began
20 at 160 per 1000. That is 16 percent of the total
21 force. And I assume they haven't rotated because
22 the next month is about 140. So that means that you
23 have got a 30 percent morbidity rate due to cold
24 injury just over a two-month period of time. Is my
25 interpretation correct?

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1 DR. SMITH: During that retreat in the
2 regiments that were in battle, cold injury rates
3 exceeded wounded in action rates and were in some
4 regiments over 900 per 1,000 per year. A bad year,
5 a bad military situation in a bad environment, and
6 the result was a disaster.

7 DR. LAFORCE: Questions? Observations?
8 I suggest that we still have a lot to learn. Yes,
9 Phil?

10 DR. LANDRIGEN: One little link there,
11 sort of a footnote on your epidemic graph of Korean
12 hemorrhagic fever, has to do with the fact that the
13 epidemic intelligence service at CDC, of which many
14 of us are alumni, was established in the summer of
15 1951 by Alexander Langmuir who knew people like
16 Chalmers. And his rationale, at least his rationale
17 on Capitol Hill for establishing the epidemic
18 intelligence service was to create a cadre of
19 people who would be deployed, at that time mainly
20 within the U.S., to be an early warning for us to
21 detect the introduction of fevers from the Orient
22 as he used to refer to them. So it is interesting
23 how these things ripple in other different
24 directions as well as along the main line.

25 DR. SMITH: Most EIS officers would be

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1 offended to know they started as a bio-war early
2 warning system.

3 DR. LAFORCE: Except that most ex-EIS
4 officers know how deft Alexander Langmuir was in
5 terms of getting Congressional support and money.
6 So many of us wouldn't be so surprised. Okay, thank
7 you very much, Dr. Smith.

8 Now it is a great pleasure to introduce
9 -- really, no other word comes to mind other than
10 legend -- Dr. Ted Woodward, who is not only a
11 distinguished Chair of Medicine at the University
12 of Maryland, but also a long, long affiliation with
13 the Board and was a president of the Armed Forces
14 Epidemiologic Board for many years. It is a
15 pleasure to welcome Dr. Woodward. Dr. Woodward's
16 presence here begins with a discussion -- again,
17 you know we were talking about Stan's influence.
18 Just over the short period of time, I remember the
19 first time we got together, we were having dinner
20 in Tijuana or somewhere. It was after the San
21 Diego meetings and Stan pointed out that we had a
22 legendary resource that was in the Washington area,
23 Dr. Woodward, and that we ought to sort of work out
24 an invitation to get you to come. And I am
25 delighted to see that that now has come full

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1 circle. Welcome, Dr. Woodward.

2 DR. WOODWARD: Thank you. When you get
3 old, all you talk about is history and your
4 grandchildren. I have got nine of those. Colonel
5 Smith took my mind back talking about Korea.
6 Because under the AFEB cloak, a team went out to
7 Korea in 1951 -- Joe Smidel, Bob Traub, Barry Wood
8 and a few others and helped straighten out some of
9 the clinical manifestations of the late shock
10 syndrome method of transmission. In as late as
11 1987, the Navy and the Army presented a Board a
12 series of questions about what to do about Korean
13 hemorrhagic fever. Colonel Smith also mentioned
14 encephalitis, Japanese encephalitis. Under the
15 AFEB, educational movies were made on arthropod-
16 borne encephalitides and it is mainly about
17 Japanese B encephalitis, and this is an excellent
18 teaching film. The AFEB has also sponsored a film
19 on hemorrhagic fever, and if you want to get in
20 touch with it, you can get in touch with the
21 photographic department of the institution that we
22 are now in.

23 Now the AFEB is a 60-year affectionate
24 marriage between the military services, Army and
25 Navy first, the Department of Defense and academic

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1 medicine. And this is the 60th year -- the 60th
2 year of that marriage. And I doubt whether there
3 are many committees in Washington who have lasted
4 that long.

5 Now call me on time, I have a bad
6 reputation. I have written -- made a little sketch
7 so I won't leave things out. Then I am going to
8 show you some pretty pictures. The quality and
9 productivity of any endeavor depends most of all
10 upon the dedication and wisdom of those given the
11 responsibility to carry out that mission. Those
12 who conceived of the Medical Advisory Board to
13 assist the Department of the Army were leaders with
14 vision. They understood the current military
15 medical problems and the perceived the health
16 matters that would plague the military in the
17 future. Not only were there men like Simmons,
18 Bayne-Jones, Blake and McCloud, able medical
19 scientists in their own right, but they also had
20 uncanny insight and common sense.

21 The Armed Forces Epidemiologic Board was
22 conceived 60 years ago as a medical and scientific
23 advisory board to the Department of the Army. After
24 World War II on advice of the Surgeon General, the
25 Department of the Army, the Secretary of the Army

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1 recommended that the AFEB be established as a tri-
2 service board. The new charter was formally adopted
3 on 8 October 1953, with the Board serving as a
4 joint agency for the three medical departments, and
5 I have copies of all the charters back here if you
6 would like to have them.

7 How many of you know that a history of
8 the Armed Forces Board and its commissions was
9 written? How many of you know that? That is good.

10 Are there any copies left, Colonel Diniega?

11 COL. DINIEGA: Yes, sir.

12 DR. WOODWARD: You do?

13 COL. DINIEGA: Yes, sir.

14 DR. WOODWARD: Really?

15 COL. DINIEGA: Yes.

16 DR. WOODWARD: I am surprised. I
17 thought they were all gone. They tell the whole
18 story, and I would say that history would not have
19 been written if this Board hadn't kept meticulous
20 minutes and if Jean Ward and Bob Wells and Nick
21 Kolowski and many others hadn't kept excellent
22 records in the AFEB office. And at this meeting,
23 speakers were asked to present their comments
24 briefly in writing. And if those records hadn't
25 been available, I can tell you those two books

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1 would have not been possible.

2 Throughout this history, the Board has
3 responded to the needs of the Services with
4 dedication, wisdom and sound advice. From its
5 inception in 1940 through 1973, the Board developed
6 and used commissions to study specific military
7 medical problems. Commission investigators engaged
8 in basic and field investigations of problems
9 relating to epidemiology and preventive medicine
10 within the military medical community and they left
11 their home offices and went to Panama and went to
12 Vietnam and went to Korea and went over the United
13 States whenever they were asked to do so under
14 aegis of this splendid Board.

15 Called on during times of peace, the
16 commissions responded willingly to the medical
17 needs of women and men in uniform. Commission
18 appointments combined with intramural research
19 benefitted the general public health as well as the
20 military and included the development of influenza
21 vaccine in the treatment and prevention of
22 pneumonia, hepatitis. When I was in medical
23 school, hepatitis was called acute catarrhal
24 jaundice. You had an inflammation of the bile
25 duct. That is what I was taught and I graduated in

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1 1938. We have come a long way, haven't we?
2 Meningococcal meningitis, rheumatic fever, tetanus,
3 diphtheria and so many others. Many leaders in
4 American medicine, busy as they were, found time to
5 contribute their capable services to this
6 remarkable system. There unstinting urge to
7 participate is attributable to their proud sense of
8 obligation and the privilege of serving our
9 country. Personal gain was not an objective. The
10 opportunities to meet with and work with and argue
11 with the leaders in infective diseases in other
12 fields during the Board meetings, work sessions and
13 small discussions were really mini post-graduate
14 learning sessions. Almost everyone took away a new
15 idea that answered a dead-end question or that
16 illuminated a detour around a difficult obstacle.
17 Information was willingly shared among civilian and
18 military scientists.

19 The spring meetings of the AFEB and its
20 working commissions usually lasted three days.
21 Those who attended these leading up to 1973 were
22 privy to hear the most current data pertaining to
23 pathogenesis therapy and control of the important
24 infectious diseases that were prevalent both aboard
25 and in the United States. Truly these three-day

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1 sessions were dress rehearsals for the later spring
2 meetings of the American Society for Clinical
3 Investigation and the Association of American
4 Physicians usually held in Atlantic City in early
5 May. The participating contributors were usually
6 the same.

7 After 1973, when the commission system
8 was abolished -- and I won't go into that, the
9 Board assumed a new role and functioned under a new
10 charter. Indeed, during a short period in the mid-
11 1970's, the Board experienced a sinking spell that
12 might well have led to its demise. Happily, the
13 Board survived. Respect and pride were maintained
14 and a good working relationship was reestablished
15 among the three military services, the Department
16 of Defense and the AFEB. Necessity also played a
17 part. In addition to the new problems that arose
18 such as the need to reevaluate the physical and
19 safety standards of military in emergence of new
20 environmental concerns, the old fashioned
21 infectious diseases, such as we have heard --
22 malaria, dengue enteric diseases, Rift Valley
23 fever, venereal disease and tuberculosis never
24 disappeared. Drug and alcohol abuse, obesity, high
25 blood pressure, excessive smoking and heart attacks

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1 were always present. Acquired Immune Deficiency
2 Syndrome provided a whole new constellation of
3 problems. I remember that meeting -- 1985. The
4 meeting was over, Dr. LaForce, and there were no
5 big problems to take home and I thought oh boy.
6 And Colonel Herbold from the Air Force -- the
7 meeting was over and I practically put the gavel
8 down. He said, Dr. Woodward, what does the AFEB
9 recommend about AIDS? I said, you know, Colonel
10 Herbold, we do not act on verbal questions. Put it
11 in writing. They broke the record. Within 2 days
12 with DoD and the military, we had the damndest
13 questions you ever -- it ruined the whole damn
14 summer. My God, because these were public meetings
15 and there was the whole idea of gay rights and
16 confidentiality. So first of all, the questions
17 went to the AFEB. And then when they learned that
18 there was a President in my office, the phone got
19 red hot all during the summer.

20 So then the head of the gay rights
21 movement, Dr. Robert Levy of New York, a lawyer,
22 kept calling me. We were going to have a 2-day
23 meeting and he wanted one day. And then there was
24 another lady named Matilida Prim. She was an
25 activist too and she kept calling. So I said, I

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1 will give you a half hour on the agenda. We have a
2 tight agenda. They wanted to bring about 25
3 representatives. I said, you can bring two. So
4 that was a very unrestful time. So I always
5 commute. That was a hell of a lot of traffic on the
6 beltway here, that is why I was late. Anyway, I
7 got here early that morning down in the War Room
8 where we met, and this had polarized the whole
9 WRAIR campus. Everybody was upset. My God, are we
10 going to have a war? We are going to have
11 everything. I got outside that room -- now listen,
12 I am not exaggerating -- and there were two
13 sergeants with all those stripes and they had two
14 side arms. Those were revolvers. And they were
15 there outside that damn door. I said, what are you
16 doing here? Well, we were told to come here by our
17 commander. I said, you get your ass off of here.
18 Can you imagine? The Washington Post, the New York
19 -- we had six newspaper representatives. You get
20 down on another floor. Could you imagine the
21 headlines there? The Army -- anyway, that is one of
22 the most important things I ever did before this
23 Board to say that right there.

24 The Board was asked to address its
25 attention to these issues and many more. To the

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1 interest and gratification of both its members and
2 those military personnel with whom the Board was
3 privileged to collaborate. I want to give you some
4 good sound advice. Don't leave the meeting early.

5 Members don't leave the meeting early. In 1979, we
6 had a meeting in San Antonio, Texas, and I was
7 running a department of medicine in a busy medical
8 school. I went down there and I left that damn
9 meeting early. I left it a half a day early to get
10 back to Baltimore. And those sons of bitches
11 elected me president. So you've got to be there.
12 And that damn thing lasted 12 years -- 1980 to
13 1992, 12 years. And they are only supposed to serve
14 for two years. So take my advice, you keep here and
15 you stand up for your own. I don't regret it at
16 all. It was one of the greatest privileges I have
17 ever had.

18 So now let me show you some pictures of
19 the old days. Okay? Now this is the old division
20 of -- we better turn the lights down -- of
21 preventive medicine. And there you see General
22 Simmons and there you see Tommy Turner on the left.
23 And there is Bayne-Jones and that is Bill Stone.
24 Next slide, please. And here you see one of the
25 early Board and here is Bayne-Jones. That is Dr.

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1 Avery. That is Ken Maxey. That is Joe Stokes.
2 That is John Dingle. That is Colin, I think, and
3 that is -- I believe Tommy Francis. I can't quite
4 -- and that is Albert, I think.

5 Next slide, please. And here is a later
6 Board showing Colin and showing Dr. Maxie. That is
7 Horshall, Dingle, and that is Tommy and that is Dr.
8 Wern. Next slide, please. And then that is Dr.
9 Simmons, who was head of preventive medicine. He
10 really and Dr. Bayne-Jones were the ones who really
11 founded this Board. Next slide, please. This is
12 Dr. -- you see, that is what happens when you get
13 older. You know as well as I know who this is. He
14 was at Yale. C'mon? Francis Blake -- of course,
15 Dr. Blake. Don't get old. That is what happens to
16 your memory. Next slide, please. He was a
17 wonderful man. That is B.J. He taught me many
18 things, including the necessity of keeping records.

19 Next slide, please. And here Dr. Blake
20 and Dr. Maxie -- because we had a lot of scrub
21 typhus in the Pacific War and it killed a lot of
22 people. Sometime in there the death rate was 30
23 percent. And these two fellows left home and went
24 out there. And this was the setting, this Kunai
25 grass, where the mice survived in scrub typhus

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1 therapy. And they, with the Board, came up with the
2 idea to burn the grass and get rid of the mice and
3 put some stuff on the ground to kill the mice.
4 Next slide, please. That was on the Board. And
5 here is the old respiratory commission and here is
6 Rammel right here and here is Dr. Hauser right
7 there. And those were the ones -- that is
8 Wannamaker, I believe. But those were the ones
9 that went out to the Air Force Base in Wyoming and
10 they are the ones that came up with the prevention
11 of rheumatic fever, as you know, with penicillin,
12 which is one of the great contributions of the
13 time.

14 Next slide, please. And they studied
15 atypical pneumonia and so its transmission. There
16 is a good picture of Colin and there is a good
17 picture of Tommy Francis. Tommy was president of
18 the Board for a long time. I succeeded Colin and
19 also Tommy was the chairman of the Cole Study on
20 Respiratory Diseases and Pneumonia. All you have
21 to do is study World War I and you will find that a
22 hell of a lot of people were put in the ground with
23 influenza and with pneumonia.

24 Next slide, please. And then this is one
25 of the great persons, Dr. Enders. And wasn't it

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1 wonderful that when they came to give him the Nobel
2 Prize for growing the virus, he said thank you very
3 much but I am not going to take it unless two
4 people in my department get that too, and that was
5 Tom Weller and Fred Robbins. How many people would
6 do that? I can tell you a number that didn't.

7 Next slide, please. There is Tom Weller.

8 He is still cooking, thank goodness. And these all
9 served intensely. That is John Dingle, who
10 practically built Western Reserve, but he was
11 really the one that ran that acute respiratory
12 commission that came up with those wonderful
13 findings.

14 Next slide, please. That is Dr.
15 Goodpastor, who -- oh, I remember him. He was a
16 man of few words, but could he really give you
17 information. He was a pathologist that ended up
18 down at Vanderbilt, of course.

19 Next slide, please. He was one of the
20 first one to use fertile eggs to cultivate
21 bacteria. And K.F. Meyer, he was a great
22 raconteur, the world's authority on plague and on
23 many diseases, including tularemia that we have
24 heard about and including leptospirosis that we
25 heard about.

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1 Next slide, please. That is Joe Stokes,
2 who practically built part of Philadelphia and
3 taught us so much about vaccines and the theory of
4 vaccines in combinations. You see, we had a whole
5 commission on immunization that developed and
6 purified vaccines.

7 Next slide, please. And then there is
8 Rammel, who was at Wesson Reserve and one of the
9 great leaders of streptococcal diseases in the
10 world.

11 Next slide, please. And there is Lou
12 Wannamaker, who worked with that team and was
13 equally effective.

14 Next slide please -- all effective,
15 modest people. And who will forget Max and Ed
16 Krauss and Bill Jordan. Bill Jordan lives not so
17 far from here and he is still cooking.

18 Next slide, please. All I had to do was
19 mention pneumonia and Max Finland and that will
20 bring back your memory. But he was very active with
21 the Board. That is Martha Pittman and that is Dr.
22 Heidelberger and that is Bill Jordan.

23 Next slide, please. And then here is
24 Krugman, who left Rochester and went out all over
25 the United States to California and found the

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1 sulfonamide resistance of the meningococcus and
2 also showed that you could use drugs to prevent
3 meningococcal disease, which we are still using in
4 school. But he just left his shop up in Rochester
5 and all the snow they had up there to go around the
6 country and help the Board and its commission.

7 Next slide, please. This is taken from
8 him. This was at Fort Ord, I think. They went out
9 and they had to shut down bases and so forth.
10 Because when you took young people, mostly men, and
11 put them in crowded barracks, they shared each
12 other's organisms and each other's diseases. That
13 is what war does. It collects a lot of semi-
14 immunologic virgins and brings them together. How
15 many of us in the room realize that the
16 meningococcus killed more soldiers during World War
17 II than any other microbe. More than malaria. The
18 meningococcus -- and it was Worth Daniels who
19 worked on this Board that said meningococcus may
20 attack so subtly as to elude diagnosis and so
21 rapidly as to outdistance treatment. That is an
22 accurate statement. Because the meningococcus,
23 when it became septicemic and hit your adrenal
24 glands and you went in shock, it didn't matter what
25 you gave them. Most of the time you were dead and

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1 that was called the Waterhouse-Friderichsen
2 Syndrome.

3 So a lot of these advances have been
4 evolved, Dr. LaForce, from your Board. Next slide,
5 please. And then that is Saul Krugman, Mr.
6 Hepatitis. I told you when I -- we didn't even know
7 about viruses when I was in medical school and he
8 helped to set that. There were two kinds of
9 viruses. And just the other day -- next slide
10 please -- I saw Maurice and he had a great deal to
11 do. He did a lot of his original work at the old
12 WRAIR and Joe Smidel was there with him. And he is
13 now Mr. Current Hepatitis. You know what he has
14 done at Merck and Company. But his basic work was
15 done at WRAIR.

16 Next slide, please. In the early days,
17 that is Bill Hammond, who put the pants on polio
18 vaccine and he was in Pittsburgh. And he with Tommy
19 Francis in the eves were the ones that showed that
20 gamma globulin or immune globulin would prevent
21 polio before Jonas came along with the vaccine.

22 Next slide, please. That is Gus Damon,
23 Dr. LaForce, who chaired the Board for a long time.
24 I think ten years. He was a wonderful
25 pathologist. And I was interested that the tick

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1 that transmits Lyme Disease was initially named
2 after Gus, Ixodes Damonaea. Now they have changed
3 the name.

4 Next slide, please. And then Cecil
5 Watson in Minnesota, who was the world authority on
6 porphyrins and things like that. He served on
7 several commissions on the Board. Next slide,
8 please. And there is Gus with his Board. I can't -
9 - I am on an angle. That is Bill and that is Floyd
10 Denny and he was on that respiratory team. That is
11 Colin. And maybe you can --

12 UNIDENTIFIED SPEAKER: Gordon
13 Nickeljohn.

14 DR. WOODWARD: There is Charlie Wissman
15 back there. Anyway, next slide, please. There is a
16 little later version of the Board. I believe that
17 is Paul Dennison. My, what a wonderful man he was.
18 And we did a survey of the whole health system and
19 he spent a whole year and that report was just
20 remarkable. Cardiovascular standards, blood
21 pressure and weight, all of those things.
22 Epidemiologic forecasting and so forth. He just had
23 a meticulous, wonderful mind. That is Hershel
24 Griffin, who served as a Board president for a
25 while. I believe that is Bob Osh.

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1 Next slide, please. And then here you
2 see Dr. Mayer, who is secretary -- a Secretary of
3 Defense and a Secretary -- the Surgeon Generals
4 came and participated in the meeting. That is
5 Leonard Curlin. That is Lou Lectors. That is
6 Norland Nelson.

7 Okay, next slide, please. And then a
8 better picture of Paul Dennison. Next slide. He
9 really more than anyone else along with Joe were
10 responsible for getting the Board involved in
11 biologic warfare defense. We had a commission on
12 epidemiologic survey, which really had its mind in
13 Detrick at USAMRID. And most of the work done at
14 USAMRID was under the auspices of the commission
15 and epidemiologic survey, a polite name for
16 biologic warfare defense energy that still exists.
17 He was a Rockefeller and I succeeded him as
18 chairman of the commission and epidemiologic
19 survey.

20 Next slide, please. And then here are
21 some of the military people again -- Dan Jones, Dan
22 Crozier and Bill Tiger, who really ran the
23 scientific program. And Colonel Randall, who came
24 up with the VEE vaccine. In the 1970's, Venezuelan
25 equine encephalitis was coming out of Venezuela

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1 into Latin and South America. Mosquito-transmitted,
2 and it looked like the horses -- all the horses in
3 the southern United States would be eradicated.
4 There were some patients -- a few died. But Pops
5 Randall at Detrick had developed the VEE vaccine,
6 living and attenuated, and then there were
7 stockpiles of it. Veterinarians went from Detrick
8 down to the south and met with the veterinarians
9 and the horses in the southern United States were
10 immunized and saved and that was under AFEB
11 auspices.

12 Next slide, please. And then here is
13 Albert and there is Philip and there is Dr. John
14 Paul. During the war, we were having trouble with
15 sand fly fever, a meddlesome not fatal disease, and
16 they went out to the Far East to help figure out
17 some of the epidemiologic characteristics.

18 Next slide, please. There is a good
19 picture of Albert, God bless him. You know, he was
20 married a long time. I take pride in something --
21 married a long time and they never had children. I
22 said, why in the hell don't you get away. She took
23 a vacation to Europe and she didn't get pregnant.
24 So tension must have something to do with it.

25 Next slide. Then that is Saul Krugman

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1 again -- no, that is Gordon Michaeljohn. He was
2 Mr. Influenza. What happened is everybody sent
3 their sera to Gordon in Denver and then he would
4 analyze the serum because the flu virus could put
5 on an extra nose or an extra eye, you know the H
6 and N antigens, and then we would have a meeting or
7 a telephone meeting and decide what was to go into
8 the new influenza vaccine that year. That was
9 based on Gordon's valuable data.

10 Next slide, please. Here is a picture
11 of the Board meeting in the Board Room. That is
12 Surgeon General Denning and that is General Taylor
13 and that is Randall. This was on a drug abuse
14 meeting. That was a tough meeting. This was
15 around the time of the Vietnam war and the fellows
16 got into cocaine and heroine and we had a big
17 problem. So the Board took that on. The Board took
18 that on. We called in psychiatrists and everybody
19 else to educate us. We had joint meetings with the
20 Veterans Administration and determined not only
21 what we would do if someone was addicted but the
22 long-term coverage. And the Board was responsible
23 for coordinating that activity. And we haven't
24 solved it completely.

25 Next slide, please. That is a picture of

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1 my dear friend Joe Smidel, who did so much for many
2 commissions -- rickettsial disease commission,
3 immunization, helped purify the small pox vaccine.

4 Rockefeller graduated from Washington University
5 in St. Louis. He lived in Bethesda.

6 That is Ken Gudner, who was head of
7 microbiology at Jefferson, and he too was very
8 important in the vaccine development program and a
9 program against cholera and so forth. Because we
10 had a commission on enteric diseases.

11 Next slide, please. Then that is
12 Charlie Wissman, who first of all worked with Joe
13 and went to Southwestern and worked with Smidel and
14 worked on toxins and helped work out the whole
15 pathogenesis and pathophysiology of rickettsial
16 diseases. He came to Maryland and was head of our
17 department of microbionics.

18 Next slide, please. Then there is a
19 picture of Bud Dennison, who is retired and still
20 living. He has done so much for surveillance. He
21 too was a product of Walter Reed and of Smidel.
22 And incidentally, when he ever turned in a report,
23 it was letter perfect. And he had them in almost
24 the next day.

25 That is Chester Keefer, who probably

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1 trained some of you maybe. He was a very active
2 participant and developed streptomycin and a lot of
3 things -- penicillin.

4 And Ed Perlong of Baltimore, God bless
5 him, who served with the Board and really was Mr.
6 Sulfanilamide.

7 That is Bob Austrian, whom as you know
8 with Dr. McCloud -- but he did it mostly himself --
9 developed a pneumococcal vaccine. Bob was active
10 on commissions and he is now in Philadelphia
11 retired.

12 Next slide, please. And that is Jeff
13 Edsel, a Harvard graduate, who was chairman of the
14 commission on immunization and had a very
15 scholastic, fertile mind. He was based at WRAIR.

16 So can we have the lights, please? So
17 that is a quick going over of the Board, Mr.
18 Chairman, and some of its accomplishments. There
19 were eight more slides to come and there was also a
20 picture of the former executive secretaries and
21 there was a picture of Jean Ward and of Jane
22 Eldridge, who were the secretaries. But I just know
23 that I am over time, and I thank you for not
24 calling me down.

25 DR. LAFORCE: I think on that note we

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1 will break for about 15 minutes and it will give us
2 a chance to chat with Dr. Woodward.

3 (Whereupon, at 9:36 a.m., off the record
4 until 10:00 a.m.)

5 DR. LAFORCE: Okay. Ben?

6 COL. DINIEGA: Sir, are we in
7 subcommittees?

8 DR. LAFORCE: We are. We are now in
9 subcommittee/executive session.

10 COL. DINIEGA: Well, do you want to do
11 the -- why don't we do the subcommittee business
12 and then go into executive session.

13 DR. LAFORCE: Super.

14 COL. DINIEGA: Because there was the new
15 question on microbial based cleaners and the
16 performance standards, and Rosie isn't here. And
17 then the other issue is if the Board chooses to
18 make any comments about the ongoing ergonomics
19 question. And I gave you the previous
20 recommendations, that they want to continually be
21 involved in either more updates and information.
22 She had some specific questions on her
23 presentations.

24 DR. LAFORCE: Right.

25 COL. DINIEGA: Which is not in writing.

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1 Which as Dr. Woodward said, put it in writing. But
2 it is an ongoing issue. So if you want to make
3 comments then or if you want to say we will wait
4 until the next meeting, that is fine. And then
5 there were several other informational briefs that
6 some people have said they may want to make
7 comments on. But there is no obligation for the
8 ones that aren't formal questions to say anything.

9 DR. LAFORCE: All right. I have five
10 issues that came up that I thought that we needed
11 to discuss. Not necessarily in subcommittee but
12 together. One was the question that came up in
13 terms of the microbial cleaners where the general
14 suggestion that came from Rosie and others is that
15 there is probably some expertise or some group that
16 already has looked at this. And what we need to do
17 is either identify that expertise from either EPA
18 or from OSHA. And I am not exactly sure how to
19 take that next step. What I was going to try to do
20 was work with Rosie and ask Rosemary to give us a
21 hand in terms of phrasing an answer to that
22 particular question. Does that sound reasonable to
23 the Board as a strategy that we could do? And then
24 what happens is when I get that back from Rosemary,
25 then I will just sort of circulate it around to all

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1 members of the Board like we have with other
2 documents.

3 COL. DINIEGA: Well, Phil is here from -
4 -

5 DR. LANDRIGEN: Could you restate the
6 question?

7 DR. LAFORCE: Sure. The question, Phil,
8 is that we have been asked to answer or to provide
9 advice, and the question relates to what about the
10 microbes that are present in these commercially
11 available cleaning solutions, that list not only
12 the presence of enzymes but also the presence of
13 microbes. And when we had the question and answer
14 session that followed that particular presentation,
15 it was clear -- or it seemed clear to me -- that no
16 one knew anything about what was going on.
17 Certainly the presenters didn't, and there didn't
18 seem to be any information that was provided to us
19 in terms of the commercial information that gave me
20 any sense of satisfaction that I knew what it was
21 that we were talking about. So my sense was that I
22 felt that the Board really couldn't give any sort
23 of informed opinion and what it needed to do was to
24 get referred back down one level to -- pardon me?

25 COL. DINIEGA: No, go ahead. I just have

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1 some comments after you are done.

2 DR. LAFORCE: No, why don't you give
3 your comments right now before I get blown out of
4 the water.

5 COL. DINIEGA: No, I wouldn't do that to
6 you. Okay, the specific thing that they want, and
7 there was a handout given out, is the Navy
8 Environmental Health Center, the State, that has
9 developed a draft set of criteria essential for the
10 adequate health hazard evaluation of such products,
11 which was enclosed. The NEHC requests review and
12 comment from the Armed Forces Epidemiological Board
13 regarding these criteria. That is the task. What
14 the letter from the SG's office states is concur
15 with the request of the Board to review and comment
16 on the proposed criteria for the performance of a
17 health hazard assessment of microbial based
18 cleaners.

19 DR. LAFORCE: Okay, fine.

20 COL. DINIEGA: So focus on the draft
21 criteria. Now the general gist yesterday was they
22 look good, it is a fine starting point. The other
23 part of the discussion was there must be some
24 agency out there that they have to run these things
25 through before they can start selling it. That is

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1 the second issue. And then just as a clarification
2 for the Board members, the way most of these
3 cleaners and solvents, et cetera, are used at least
4 that I know of in the Army is that they actually
5 can go out and purchase anything they do except in
6 certain settings. I know in hospital settings there
7 is an approved list of some sort that you can only
8 use those on the approved list. Now industrial
9 operations -- let's see, Ben used to be at AMC, but
10 at the headquarters level. I don't know what their
11 -- you know, how they go about deciding what
12 solvents and cleaners and detergents to purchase.

13 DR. LAFORCE: Yes?

14 DR. ALEXANDER: I think our comments
15 really were in terms of who to send this to. We
16 are at two levels. One was the occupational health
17 exposure, the NIOSH recommendation that Rosie made.

18 My recommendation was at the individual consumer
19 level, if there is a consumer product safety
20 commission whose task it is to evaluate products
21 that are on the market for the general public. And
22 it would be interesting to see whether they have
23 done their usual rigorous evaluation of these types
24 of products and what they recommend to the John Doe
25 consumer as well as the population-based purchase

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1 that would be reflected in this sort of work
2 environment framework that was posed. But I think
3 we also want to echo that the rigor of the
4 questions that were posed was really quite
5 impressive, and that would be a valuable framework
6 to any referral agency if they had not already
7 created an infrastructure for evaluation.

8 DR. LANDRIGEN: One thing that I will --
9 I am sorry I missed that discussion yesterday. As
10 I told you, I was downtown at HHS in the afternoon.

11 But one -- there is actually a whole literature in
12 the occupational medicine field on these enzyme
13 cleaners. It mostly was published in the 1970's in
14 the British Journal of Industrial Medicine and the
15 Scandinavian Journal of Work Environment and
16 Health. They had some really severe problems with
17 these enzymatic cleaners in Europe, to the extent
18 that a lot of the European countries have banned
19 their use. And the problems have been allergies and
20 asthma. In some of the factories where these
21 products were produced, they used e.coli, I think,
22 that had certain enzymes in them. And there was
23 like a 25 or 30 percent prevalence of asthma
24 developed among people employed in the factory who
25 were making these things. What I seem to recall is

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1 that people that have preexisting atopy, allergic
2 predisposition, were at higher risk. But even
3 people that had no past history of allergy or
4 eczema had a pretty good prevalence.

5 She is diseased now, but the grand old
6 British occupational epidemiologist Murial
7 Newhouse, Molly Newhouse, was the person who did
8 most of the work on this. She was one of my
9 instructors the year the CDC sent me to the London
10 School of Hygiene. So I remember it really quite
11 vividly. Those papers are out there. I don't know
12 if the folks who presented this talk yesterday were
13 aware of that. It is sort of old literature and
14 may predate Medline, but it was quite real at the
15 time.

16 DR. HAYWOOD: The question is did it
17 lead to some procedures, regulations or standards
18 of some sort that have to be met?

19 DR. LANDRIGEN: I think it mostly led to
20 banning. That the stuff was so hot that --

21 DR. HAYWOOD: Well, that is what I
22 meant.

23 DR. LANDRIGEN: They didn't need it.

24 DR. ATKINS: But, Phil, do you know is
25 our assumption true that there is some agency that

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1 has jurisdiction over things that are non-chemical?

2 I mean, my concern is that these might be like the
3 food supplements where they have gotten sort of
4 through this loophole of being natural products
5 that aren't regulated. If they are not regulated,
6 then the company has no interest in collecting more
7 information. So they may not actually have any
8 more information to give to us about exactly the
9 chemical constituents because there is no
10 motivation to.

11 DR. BERG: They may have slipped through
12 a loophole, but what bothers me is it is not clear
13 how diligent a search they may to see whether they
14 are under any regulatory agency.

15 DR. LANDRIGEN: The Consumer Product
16 Safety Commission is -- it is mostly a paper tiger.

17 And I would be surprised if they had offered any
18 opinion whatsoever in this stuff. There is
19 probably a couple of folks at NIOSH who have
20 tracked it and the person I would get in touch with
21 is Bill Halperin, who was previously the Deputy
22 Director of NIOSH and then went back to Cincinnati
23 to be a working epidemiologist.

24 COL. DINIEGA: Rosie was --

25 DR. LANDRIGEN: And Rosie too.

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1 COL. DINIEGA: Rosie had said that she
2 was going to look at it from the NIOSH point of
3 view.

4 DR. LANDRIGEN: NIOSH would have more
5 than OSHA. I don't think it has ever come to OSHA.

6 COL. DINIEGA: But who banned it in
7 Europe?

8 DR. LANDRIGEN: I am pretty sure the
9 Brits did through the Health and Safety Executive
10 as a workplace hazard.

11 DR. MUSIC: I agree with Phil about
12 contacting Bill Halperin. But for the record,
13 Halperin has left NIOSH and is the Dean of the
14 School of Public Health at Rutgers, I think.

15 DR. LANDRIGEN: That is right. Yes, you
16 are right.

17 DR. MUSIC: But Rosie agreed yesterday
18 that no matter what this would be a NIOSH issue
19 from the point of view of worker safety. So she
20 would be very happy to work on this.

21 DR. LAFORCE: What I would propose is
22 that Rosie and Phil, if you could sort of wrestle
23 through the request for the question that has been
24 proposed, and we will coordinate it through Ben and
25 myself. And then we will involve individuals after

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1 that first cut. Would that be fair enough?

2 DR. LANDRIGEN: Yes, that is fine.

3 COL. DINIEGA: Let me just review the
4 way we have been doing this stuff. The people who I
5 have worked with when they take leads in writing
6 recommendations. Correct me if I am wrong about the
7 procedure. But normally somebody drafts up the
8 thing and sends it around through the subcommittee.
9 They draft it after a subcommittee meeting. In this
10 case, this is the subcommittee. Or you and Rosie
11 can draft it. And then once both of you feel that
12 it is where you want it to go, then we will run it
13 through everybody else.

14 DR. LAFORCE: Through you.

15 COL. DINIEGA: Yes, through me and I
16 will send it out. And then they will have time to
17 comment and we will bring it back and we will cc
18 you comments too to see whether or not you want to
19 incorporate or ignore or take under advisement
20 their comments. And then it is ready for final.

21 DR. LANDRIGEN: Yes, that is how we did
22 squalene.

23 COL. DINIEGA: Right. And I think that
24 works best. And what I normally will do is -- the
25 general rule is if we don't hear from you by such

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1 and such a date, that means you concur. And I know
2 some people are out of the country and stuff. There
3 was a period in this last bunch of recommendations
4 where I was in the office only for three days and
5 then I was going to be -- I was gone three weeks,
6 in the office three days, and then I was going to
7 be gone another three weeks, so we had to squeeze
8 everything in. But I think that works best rather
9 than trying to have face to face meetings. When you
10 get beyond one or two people drafting up a
11 recommendation, it really takes a long, long time.

12 DR. HAYWOOD: In this particular case,
13 it would be useful to have a little preamble. In
14 other words, what the background is and what you
15 are finding.

16 COL. DINIEGA: Right. And I will edit so
17 that we know when the meeting was and which service
18 asked the question and what the question was. And
19 we are now attaching the question as an attachment
20 to the recommendation. So there is no doubts for
21 the people who read it who asked and why they
22 asked.

23 DR. GARDNER: It would be nice if this
24 led to some policy in the military that even if the
25 company is not willing to release the ingredients

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1 and we can't evaluate exactly what the effects are
2 that there is a ban.

3 COL. DINIEGA: Well, I would --

4 DR. GARDNER: That would be a precedent
5 which would help us get supplements out of the
6 exponents.

7 COL. DINIEGA: Well, I would recommend
8 that the Board focuses on medical issues only.
9 Because when you get into logistical stuff, we are
10 not logisticians and that sort of stuff.

11 DR. LANDRIGEN: And we will refrain from
12 commenting on the brand name, which is Nature's Way
13 weapon cleaner.

14 COL. DINIEGA: Yes, I would keep it any.

15 DR. ALEXANDER: That is very 60's.

16 DR. LAFORCE: The late Stanley Kubrick
17 might have had some fun with this.

18 COL. DINIEGA: So as I understand it,
19 Phil, you will be sending me something.

20 DR. GAYDOS: A cool fuzzy jacket, right.

21 DR. LAFORCE: Yes, Joel?

22 DR. GAYDOS: Just one comment while you
23 folks are looking at this. Weapons are a unique
24 area and they are unique because you get
25 tremendously high temperatures in there and there

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1 are a lot of chemical reactions that occur during
2 the firing of the weapons and there are a lot of
3 residues that result. I would ask you when you
4 consider this to look not only at the cleaning
5 effect, like if you are cleaning just a surface
6 inside of the storeroom or something like that, to
7 look at possible use of these inside the bore of
8 some big gun and what might happen to whatever
9 residues are left in there when you get other
10 chemical reactions with the extremes of temperature
11 that occur in that chamber with something left in
12 there.

13 DR. LAFORCE: I would say that -- Ben
14 brought that up last night when we were having
15 dinner. Ben brought the same point. He said,
16 look, there may be another level of complexity to
17 the question that has to do with the residues that
18 are present, exactly your point, Joel. And would
19 it be appropriate to perhaps ask you or if
20 individuals, that is either Phil or Rosie, have
21 questions at a level a little bit below that they
22 can call upon you?

23 DR. GAYDOS: Well, actually the people
24 at NEHC and the people up at CHPPM would certainly
25 be able to provide the information with regard to

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1 the current systems that are out there. Certainly
2 CHPPM is supposed to be evaluating all of the
3 military systems from a health standpoint, and they
4 should know exactly what is happening inside the
5 chambers of the weapons that are being used. I
6 don't know if you are aware of this, but there has
7 been a lot of concern in the past about exactly
8 what is being produced. There has been a lot of
9 concern about the carcinogenicity of some of the
10 residues and other harmful effects that might occur
11 to the people who take care of these things and man
12 them.

13 DR. LAFORCE: One of the things I am
14 always a little afraid of is when people say people
15 at CHPPM as differentiated from Smith at CHPPM or
16 Jones at CHPPM. It would be much easier for us if
17 there is a name of somebody that we could contact.

18 Because once you start making a phone call that
19 way, having been through that in the past -- I
20 mean, if you want to throw away a day, that is
21 easy.

22 CAPT SCHOR: Well, I guess Captain
23 Bohnker at NEHC, but the originator is Captain
24 Betts. He is the one that led the charge
25 initially. He is the one that has got to deal with

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1 this at NEHC.

2 DR. GAYDOS: Isn't he up at CHPPM?

3 COL. DINIEGA: No, he is at NEHC.

4 DR. GAYDOS: Well, I know that he is
5 tied in to both the Navy and the Army communities.
6 So he should be able to direct you in both
7 services.

8 DR. HAYWOOD: Is there a command within
9 the military that is responsible for looking into
10 that sort of thing, independent of whether the
11 product is new or not?

12 DR. GAYDOS: Speaking for the Army to
13 the best of my knowledge, there is still a
14 regulation which was drafted about 1982 which says
15 that all products and devices -- not speaking
16 medical now, these are things out in the field --
17 product improvements or new developments have to at
18 some point in that logistical cycle undergo a
19 review by the medical community looking at health
20 aspects.

21 COL. DINIEGA: And that is what NEHC
22 does for the Navy and that is why they came up with
23 -- you know, they mentioned a health hazard
24 assessment. That is what they are trying to do.

25 DR. LANDRIGEN: Off line could I ask you

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1 to give me a name and a phone number?

2 CAPT SCHOR: I would have to search. I
3 don't have that information.

4 COL. DINIEGA: I have it. Again, I will
5 have to send it to you by e-mail.

6 DR. LANDRIGEN: Thanks.

7 DR. MUSIC: Just to assist Bill because
8 he wasn't here during the discussion, but there is
9 another complexity. Not just a residual, but a
10 nuance that presenters discussed. What about the
11 use of this as a degreaser. If they contaminate
12 jet fuel or if it is used for sabotage to create a
13 problem. The illustration he used was a jet taking
14 off and then running out of fuel because something
15 ate up all the fuel.

16 DR. LANDRIGEN: I guess bacteria. It
17 would be great for toxic waste sites.

18 DR. MUSIC: So it is beyond the medical
19 business, but focus on the medical with these as
20 potential areas to discuss.

21 DR. BERG: And the origin of this and
22 why the Navy is particularly concerned is within
23 the close space and closed ventilation system of
24 the ship -- they were trying to get rid of the old
25 cleaners with the volatile fumes that went around

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1 it. But I can see these enzymes getting dried and
2 shifting around also. In fact in the Navy, nothing
3 can go on board a submarine that is not first
4 evaluated for medical hazards.

5 CDR LUDWIG: I am not familiar with the
6 types of things that are being used to clean aboard
7 Coast Guard cutters, but I will ask around. There
8 may be some knowledge about that also because it is
9 used for -- a similar product is used for oil
10 clean-up. Also, there may be some knowledge in the
11 Coast Guard regarding this. If you wouldn't mind
12 sort of including me on an e-mail string so I can -
13 - or what I will do is I will refer you to the
14 person in safety.

15 COL. DINIEGA: Is that Captain Fajado,
16 the Coast Guard Op Doc?

17 CDR LUDWIG: He is. But I am not sure -
18 - I will have to ask around to see who would be the
19 one which is dealing with that. I would appreciate
20 it. Thank you.

21 DR. LAFORCE: Thank you. Fair enough in
22 terms of this issue then?

23 DR. LANDRIGEN: Time table?

24 COL. DINIEGA: Usually four to six weeks
25 for a draft. And then we take about two to three

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1 weeks to staff it. But usually at the end of two
2 months, we have a product ready for a signature.

3 DR. LAFORCE: Okay. That was the only
4 formal question that we had.

5 COL. DINIEGA: There is the ongoing
6 relationship of the Board with the Ergonomics Work
7 Group. As a refresher, the Work Group I gather is
8 working on its cost benefit model. And their plans
9 are to finalize it in December and stick it on the
10 Web base so that local users can access this model
11 and plug in their own numbers. I think what we had
12 concluded at the end of her talk was, one, when
13 that model is complete, maybe we should review it
14 here. And two, they had sent out a survey to all
15 the services saying tell us about your service
16 ergonomics program. What are the resources
17 dedicated to it, et cetera? And I think something
18 about what policies they have. And they were going
19 to try to gather up that information by the end of
20 October, which I think would be good for the Board
21 to hear the results of what that survey was at the
22 next meeting. A lot of the members and myself were
23 overwhelmed and said they are trying to do it all
24 when they should focus a little bit and there were
25 discussions about focusing on a specific type of

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1 injury or musculoskeletal disorder or focusing on a
2 particular group like the medics or nurses, one
3 that actually work in that military occupational
4 specialty, or the infantry or something. And use
5 that as a test bid for the model before trying to
6 do the world. And I think that at the last meeting
7 the recommendations were drafted by -- primarily
8 through the Environmental Occupational Health
9 Committee and Dr. Andy Anderson took that, and Dr.
10 Anderson has rotated off.

11 DR. LAFORCE: But the specific
12 recommendations that were made was the -- and I
13 think it is appropriate to go through these to see
14 if there needs to be a modification.

15 COL. DINIEGA: Right. And they had a
16 copy of these.

17 DR. LAFORCE: Because I would share a
18 bit of my concern in terms of the presentation
19 itself that -- and I think, Linda, you also had
20 some difficulty with it. It just seemed frankly
21 too comprehensive and was likely -- I thought that
22 their end date was very ambitious given the scope
23 of the work and the activities that they had in
24 mind. The Board I thought had two concrete
25 suggestions. One, Stan's point in terms of either

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1 concentrate on one group, whether it is the war
2 fighter or the enlistee or whether it is a more
3 select group, either nurses or corpsman, and to
4 test the model out in a more focused approach. And
5 we had hoped that when they developed -- or in
6 developing their framework to do that, they could
7 share that with the Board before they actually got
8 started. That was certainly my recollection of
9 this.

10 DR. ALEXANDER: I was really worried
11 because each of the individual data points was
12 quite soft. And so the cumulative total creates a
13 formula that is inherently weak. And, you know, the
14 validity of the product would be very questionable
15 given how weak the infrastructure was. So it would
16 be better to have a model with fewer variables
17 where the variables were of higher quality than to
18 have this amorphous structure that really was going
19 to produce an irrelevant product.

20 DR. BERG: It seemed as if they were
21 trying to include every possible data point that
22 might conceivably impact on it. And they did not
23 address how much time and effort would be involved
24 in collecting all that information.

25 DR. ALEXANDER: And each one was

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1 squishy.

2 COL. DINIEGA: Well, you know -- go
3 ahead.

4 DR. LANDRIGEN: I had a comment too, and
5 it was sort of what we were talking about
6 yesterday. That is that the document here presents
7 the problem as pretty much solely a medical
8 problem. It talks about collecting data in a
9 standard surveillance mode and making those data
10 available. And one of the lessons that has come out
11 of manufacturing industry in the states is that
12 ergonomics is much more than a medical problem.
13 Really you can only solve the problem if you look
14 at the whole organization of work -- the pace of
15 work, the postures in which people work, the tasks
16 that they are expected to undertake. The only way
17 that big industry has been able to knock down the
18 rates of these diseases, which are the single most
19 rapidly escalating category of occupational disease
20 in the country today, is to make line managers
21 responsible for the control. And I realize that
22 there comes a point where our grasp could easily
23 exceed our reach here if we are telling the line
24 what to do. But I would predict that as long as
25 this is solely a medical problem or seen solely as

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1 a medical problem, we will not control it.

2 COL. DINIEGA: Well, the interesting
3 thing is that the Ergonomics Work Group is
4 chartered under a non-medical agency. It is under
5 the Assistant Secretary of Defense or under the
6 Secretary of Defense or Environmental Security in
7 Installations. So in order for them to bring the
8 question to the Board, they have to route it
9 through health affairs. And the answer was routed
10 back through health affairs and down to them.
11 Members of the work group -- there are a lot of
12 medical members on the work group, but it is
13 chartered under a non-medical agency.

14 DR. LANDRIGEN: That is still a staff
15 agency, right? Not a line? Environment?

16 COL. DINIEGA: Environmental Security is
17 considered -- I guess it is a support, but on the
18 line side.

19 DR. GARDNER: It is non-medical.

20 COL. DINIEGA: It is non-medical and it
21 is a support more directly of the line.

22 DR. GARDNER: That is an advantage
23 because you have the safety personnel who are
24 integrated with the line units. That way you can --
25 if it comes through safety channels, it comes

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1 through as part of the line program as opposed to
2 the medical program.

3 DR. LANDRIGEN: Yes, I got into contact
4 with this through the thing I was talking about
5 yesterday about like consulting to Chrysler
6 actually to a joint labor management thing, UAW and
7 Chrysler. And there were a couple of factors there
8 that enabled them to get on top of it. One is that
9 the VP at Chrysler, who is responsible for health
10 and safety costs through their insurance program,
11 is also the guy who is in charge of their worker's
12 comp program. So the fact that he is double-hatted
13 avoids the situation that usually applies where the
14 costs that result from these diseases accrue to
15 somebody else. In other words, one person bears the
16 brunt and a different person pays the price. That
17 is a great formula for non-action. And when he
18 realized that he was getting hit with the cost no
19 matter which pocket it came out of, he set about
20 instituting a system where line managers are
21 responsible for controlling the disease and their
22 annual evaluation, which in the automotive industry
23 translates to their bonus, is keyed to the rate of
24 disease in their plant. It requires some fairly
25 profound thinking that goes way beyond the standard

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1 medical thinking.

2 DR. LAFORCE: Yes, Ken?

3 CAPT SCHOR: I guess my concern is that
4 I don't know anybody who is on -- the Environmental
5 Safety folks. I run into them with the Injury
6 Prevention Committee and that is about my only
7 knowledge of that. And I don't know much about this
8 area, so I am talking as an outside. But from sort
9 of a policy and execution standpoint, I see the
10 phenomenon, as I listened to the presentation
11 yesterday, of well we can fix it if we do a cost
12 benefit analysis. I am not quite sure if even that
13 as a starting point is the appropriate way to go.
14 It may be the business model applied appropriately
15 or misapplied. It then may be by saying that, well,
16 where do we put this stuff in this model -- oh,
17 medical, you have to give it to me. As a flight
18 surgeon, it is the engineering -- it is turning the
19 medical for the engineering approach to the
20 critics. Well, gee doc, that body is broken, fix
21 it. And as those of us as clinicians understand,
22 that is not always a simple answer and it is not
23 always reducible to a cost benefit model or any
24 kind of a model. So I am a little concerned that
25 that whole effort may be misdirected. Again, I

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1 don't speak with any great personal knowledge or
2 authority in this area, but that is my concern. I
3 agree that tying together the people that are
4 responsible for this that bear the cost -- you
5 know, my understanding of some of the new
6 Presidential directives that make installation
7 commanders bear the cost of their non-active duty
8 that really are civilian workers, that is a big
9 deal. In the Marine Corps, they are looking at
10 that real closely now. Because it comes out of that
11 base commander's pocket. It means he can't spend
12 money on fixing potholes in the road or something
13 else. So there are some interesting keys that are
14 in this, so that we are not splitting those things
15 up. But I am a little concerned that maybe we are
16 trying to create a model that can't really answer
17 anything. Or if you create a model, you've got to
18 start real small and add variables rather than
19 being inclusive from the outset.

20 COL. DINIEGA: Well, let me quote from
21 the recommendations. "The AFEB supports the
22 strategy to develop and utilize the cost benefit
23 model." And then it goes on to say, "The model
24 will assist DoD and installation level commanders
25 understand where they have prevention weaknesses."

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1 Then it goes on to say, "Find out the costs and
2 learn the benefits they can expect to accrue from
3 additional focused ergonomic injury prevention."

4 DR. LAFORCE: David?

5 DR. ATKINS: I think I am echoing a
6 number of concerns that people have raised. It
7 seems that the motivation behind the cost benefit
8 model was to convince people it was worth spending
9 money to address this problem. And we all -- and
10 that led to trying to incorporate all the potential
11 benefits in a very comprehensive but squishy way.
12 And I think we all have concerns about the rigor of
13 that model and just the difficulty of producing it.
14 So I wonder if that is really the right approach or
15 whether a simpler cost benefit approach could at
16 least identify the high priority areas or identify
17 from within some possible strategies where the best
18 payoff would be, without trying to hammer down it
19 is actually going to save the military money or
20 whatever. At least narrow in on the narrow set of
21 priorities. Because I don't know that a cost
22 benefit model is going to convince a line
23 commander, oh okay, I am now going to invest a lot
24 of money in changing around our operation.

25 CAPT SCHOR: Apparently the customer is

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1 the installation commander. That is the focus of
2 effort. That is your aim point with this.

3 COL. DINIEGA: But we are talking about
4 --

5 CAPT SCHOR: So I don't know if they
6 have asked the installation commanders what do they
7 need to know to prioritize their decisions.

8 COL. DINIEGA: We are talking about the
9 primarily civilian work force if it is installation
10 managed. Because they pay the disability costs for
11 civilian workers.

12 CAPT SCHOR: Right.

13 COL. DINIEGA: But they don't do the
14 military -- the active duty disability.

15 DR. LANDRIGEN: Was the Board presented
16 surveillance data showing trends over time and
17 prevalence rates of carpal tunnel syndrome?

18 DR. LAFORCE: The first one, yes.

19 DR. LANDRIGEN: They were.

20 COL. DINIEGA: This time, she presented
21 -- there were some rates on all musculoskeletal
22 disorders with no breakdown.

23 CAPT SCHOR: And that was all active
24 duty. All of her data was DMED, which is only
25 active duty.

DR. LAFORCE: You see, my

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1 perception is a little bit different than yours,
2 Ben. I thought that this wasn't just civilians. I
3 thought that this was aimed particularly at active
4 duty personnel. Do I have that all wrong?

5 DR. ALEXANDER: I thought it was active
6 duty. I hadn't realized that the local installation
7 commander is responsible for the disability
8 benefits for that installation.

9 COL. DINIEGA: For payments, yes.

10 DR. ALEXANDER: That is a huge price
11 tag. I didn't get that message in her presentation.
12 Maybe I slept through that part.

13 COL. DINIEGA: And there is a -- let's
14 see, occupational medicine. There is, I think, a
15 Presidential Directive to reduce disability costs
16 among federal workers.

17 CAPT SCHOR: And their matching goals --
18 this comes in through this injury prevention
19 committee that I also sit on. It is that they are
20 grading bases based on their rates. It is a fairly
21 public grading system. That even makes the
22 installation commanders more uncomfortable.

23 DR. LANDRIGEN: Does that refer to both
24 the uniformed and the civil side of the house?

25 CAPT SCHOR: My understanding is it was

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1 only civilian. That was their hard -- there is no
2 other way to track -- I mean through DMED you can,
3 but that is pretty squishy in that area. But
4 compensation costs are what they are tracking.

5 COL. DINIEGA: And, you know, the
6 impression was by most people that the variables in
7 the model -- the required variables on active duty
8 personnel, installation commanders per say, unless
9 they are a TRADOC or something, do not care about -
10 - I can't say do not care -- don't have any
11 involvement in the disability of active duty
12 personnel.

13 DR. MUSIC: But they have involvement in
14 the lost work days and the unavailability for
15 missions.

16 COL. DINIEGA: The units do, not the
17 installation commanders. The unit commanders.

18 DR. GARDNER: When they switched over
19 the workman's compensation to come under the
20 installation commander's budget, that suddenly got
21 their attention and things started changing to
22 reduce those workman's compensation costs. And the
23 idea of this whole ergonomics program is to make
24 the same economic argument for the active duty
25 military with a cost benefit analysis. And I really

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1 believe you are not going to get anywhere unless
2 you can make the economic argument because the
3 money drives everything.

4 DR. LAFORCE: To a base commander.

5 DR. GARDNER: And a unit -- well, and
6 the TRADOC command. And the TRADOC policy as to
7 how things are going to go through. To all of the
8 senior commanders, if you can demonstrate that if
9 you change your process, you are going to save
10 personnel time and person availability and money,
11 then they are going to implement that policy. If
12 you say it is not going to save money, then they
13 don't care. That is what is going on with
14 adenovirus.

15 DR. LAFORCE: Let me make sure I
16 understand this now. It sounds as though the
17 problem as it is related to civilians has been
18 fixed through Presidential Directive by direct
19 fiscal accountability. So, therefore, that has got
20 their interest and they are looking at that already
21 carefully. So that there isn't a whole need for a
22 new process to look at civilian related activities
23 as a result of this Presidential Directive.

24 DR. GARDNER: Just this year. The
25 President Directive came this year, but the

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1 beginnings of this transfer was several years ago.

2 CAPT SCHOR: Then I would suggest now
3 that the responsibility has -- now that the
4 commander has the purse strings, they are frantic
5 to figure out how to eat the elephant -- which part
6 to start on. So I think that may be where the cost
7 benefit model concept came in. How do we stratify
8 -- you know, where do we go after first.

9 DR. LAFORCE: And that is why active --
10 yes, Joel. I am sorry.

11 DR. GAYDOS: If I can put this into
12 perspective, and I am sure that if I give you some
13 dated information our uniformed attendees will
14 correct me. If you look at the work forces under
15 the Department of Defense umbrella, the military
16 work force comes under the military commanders. And
17 the military commanders are the ones that are
18 responsible for managing risks and they are the
19 ones who have to deal with claims like disability
20 in terms of time off work and that sort of claim.
21 So, for example, if you have a military exposure --
22 let's say there is an eye-hazardous area, the
23 military commander is responsible for making sure
24 that eye protection is procured using their budget.
25 Now the military uses a lot of equipment and a lot

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1 of this has ergonomic hazard associated with it.
2 The military is supposed to be taking care of that.
3 And again, that is supposed to be in their material
4 acquisition and decision process. So if they are
5 coming up with a new way of getting an aircraft
6 mechanic up into the tail section of a plane or
7 something, they are supposed to be looking at that
8 and evaluating it. When they design a new armored
9 vehicle and somebody has to load shells, they are
10 supposed to be looking at the space required, the
11 movements required, the weight required and all
12 those sorts of things. They are supposed to be
13 looking at vehicles to make sure that they are --
14 vehicles are being developed so that men and women
15 can operate in those. But that system is supposed
16 to be built into what they are doing in terms of
17 purchasing equipment. Colonel Lopez mentioned
18 yesterday problems with the rucksack. Now that I
19 found a little surprising because that rucksack
20 should have been thoroughly tested at a place like
21 Native Laboratories before it went out into the
22 field under all sorts of circumstances. So if they
23 had problems with that, those should have been
24 detected before that went out. But nevertheless,
25 that is a military problem. There are issues, there

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1 are disability issues. Those are hard to track.
2 Those are very hard to track. Because it is very
3 difficult short of hospitalizations to track what
4 is happening with the military work force.

5 Now the military organizations are on an
6 installation. And that installation has a lot of
7 civilians. Generally the case is that the
8 installation commander is given a budget for
9 operating that installation, and that includes
10 probably the majority of the civilians and that
11 comes under your OPS or Workman's Compensation
12 programs. So that is what generates your workman's
13 compensation claims. Now that is something that
14 can be tracked. That is something that comes back.
15 Those used to be paid at a very high level and now
16 they are being localized down to the commander
17 level. So the commander is faced with dealing with
18 that situation. Now my experience with that at the
19 installation level with regard to ergonomics is how
20 do you deal with this ergonomics situation.
21 Because there are a lot of people out there trying
22 to sell them rather expensive evaluation techniques
23 -- coming in and putting video cameras in places
24 and a whole lot of complicated things with
25 keyboards, and it is a very difficult situation for

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1 them to deal with. Some of the situations that I
2 was involved with were very straightforward. For
3 example, one of the depots had a situation where
4 they had an assembly line operation that was just
5 an unbelievable situation where they had people
6 actually twisting, bending and picking up weight
7 and twisting and bending and they had all sorts of
8 problems. I think they did get some extremely
9 costly evaluation done at that point. I think it
10 was a common sense type of situation. And they
11 ended up putting a robot in there at that
12 particular workplace and the workman's compensation
13 claims just went way down.

14 My experience with this has been when
15 you talk about all the problems that you have with
16 secretarial staff and you have all the keyboards
17 and the other things out there, how do you put this
18 into perspective. That is what I think is the
19 practical part of it. There are heavy industry
20 types of operations. There are a whole lot of light
21 secretarial types of operations and installation
22 commanders have lawyers at the door every day. They
23 have all sorts of people trying to get a piece of
24 their budget. And they have the workman's
25 compensation claims which I think have some value.

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1 There are limitations on those. But my perspective
2 is that that is the way that they are -- that is
3 the way they view the problem, which is I think
4 pretty much the way that Ken has tried to state it.

5 So I can visualize this as to the installation
6 commander. I have a lot of trouble seeing how this
7 is going to be applied to a military organization.

8 DR. LAFORCE: Yes?

9 COL. DINIEGA: Regardless, I'll get back
10 to Linda's point, which is I think that if the
11 Board is recommending that a cost benefit model be
12 developed, which is what they are recommending,
13 that you need to have one that is going to be
14 easily usable and that you can scientifically
15 justify the input that you are putting in there. If
16 you end up with so many variables and so much
17 uncertainty, that it is just uncertainty on top of
18 uncertainty and you can come up with any cost
19 benefit you want and that doesn't mean it
20 necessarily translates into anything that anyone
21 can defend. So I listened to that presentation too
22 and thought not only were there too many variables,
23 but probably there were too many variables that
24 nobody had good data on. So I think that to the
25 degree it can be simplified so that it is usable

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1 while still scientifically defensible, that is what
2 it ought to be.

3 DR. BERG: It seems to me that the
4 distinction between civilian and military in a
5 sense is an artificial one. Because regardless of
6 who this is targeted at, the concern of injury
7 prevention is coming up more and more on the
8 military side as Ken has said. So ultimately this
9 could be a dual purpose tool. The other thing that
10 struck me is that what they are looking for is not
11 so much to convince us that this makes sense -- you
12 know, prove that we are going to have benefits --
13 but looking for a tool that will say is this fancy
14 chair that only costs \$350.00 really worth it for
15 the secretary who says her back is hurting or is
16 there something else we can do. They are looking
17 for a tool that would let them do some of this
18 analysis.

19 DR. LANDRIGEN: It is sort of a good
20 news/bad news story. The good news is that as you
21 describe with the episode with the robot, Joel,
22 that smart, common sensical people with some
23 training can make a difference and differences have
24 been demonstrated. They are in the literature that
25 certain fixes work. And the bad news, which you

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1 also noted, is there are some real snake oil
2 salesmen out there making some very large dollars
3 putting out some dubious remedies.

4 DR. ALEXANDER: Nature's Way.

5 DR. LANDRIGEN: Well, I don't know about
6 that. No comment. But the trick is how does a
7 base commander who is confronted with six different
8 consultants make a rational choice among them. I am
9 not sure the cost benefit analysis is going to help
10 there, but I am not sure what will either. I am
11 not
12 -- I am somewhat at a loss to think of the next
13 step.

14 DR. LAFORCE: We are going to need to be
15 more specific than some of the rather general
16 comments that I have heard. And it sounds like the
17 specificity is likely to be to ask Colonel Lopez to
18 focus more narrowly along, again, a more defined
19 track and bring that plan back to the Board for a
20 looksee. Is that --

21 DR. ALEXANDER: I think, you know, along
22 that line, we didn't have time to go into a lot of
23 discussions with her. But has there been a
24 comprehensive review of the literature? DoD can't
25 be the first guy out here pondering this problem.

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1 Has Chrysler or has Campbell Soup or has Pepsi
2 taken a look at specific occupational specialties
3 where those variables or those algorithms have been
4 worked out where there might be an opportunity to
5 adapt or modify something developed in the work
6 force that would have more scientific validity and
7 reliability than every variable that she presented
8 that needed estimates. I was walking away with the
9 feeling that we were going to end up with this
10 garbage in/garbage out concept because everything
11 was going to be sort of theoretically or creatively
12 determined. And that, while it might produce a
13 product, wouldn't have any true validity.

14 COL. DINIEGA: You know, what does she
15 need -- or what does anybody need out there. You
16 have a whole bunch of disabilities. Take military
17 or civilian, it doesn't matter. It is hitting you
18 in the pocket either through lost personnel or cost
19 and replacement costs, if you have somebody you are
20 still paying for and you need to cover the job
21 temporarily. So what is causing the disability is
22 one question and which category -- if I am going to
23 do an intervention program, which category of
24 etiology should I focus my efforts on. And once
25 you decide which category, the other thing is the

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1 best practices or what is in the literature. What
2 intervention works best in that category? And you
3 may apply one that you choose is the best or two or
4 three and evaluate it.

5 I am not so sure we are -- I know the
6 whole ergonomics issue in DoD is very confusing
7 because we have so many different types of work.
8 When you say work force, you can look at the
9 industrial-based work force, which is more like a
10 Daimler-Chrysler plant in the industrial-based part
11 of the military. You can look at the occasional
12 thing that we do out in the field as part of
13 routinely being a field soldier as work and a work
14 process. And then you can look at the civilian
15 employees that do the secretarial work and whatever
16 else. I am not so sure -- I think the cost benefit
17 model they are proposing is to look at an
18 intervention and see if it is working. That is what
19 I think the cost benefit model was supposed to do.

20 But it sounds like you need help in identifying
21 the group to focus on.

22 DR. LANDRIGEN: It all begins with
23 surveillance.

24 COL. DINIEGA: Yes, that is what it
25 sounds like. How do we prioritize what we are

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1 going to try to do with this ergonomics
2 intervention, realizing that not all
3 musculoskeletal diseases are ergonomically related?

4 DR. LANDRIGEN: And not all work groups
5 are equal.

6 COL. DINIEGA: Right.

7 DR. LANDRIGEN: I mean in any work force
8 there are clear distinctions and there are usually
9 hotspots.

10 COL. DINIEGA: Right.

11 DR. LAFORCE: Remember, the
12 recommendations that were made before -- I would go
13 to D and E recommendations. The D and E
14 recommendations suggested that various data
15 collection systems can and should be evaluated. So
16 there was concern the last time we went around that
17 we ought not to look at this as this being a done
18 deal. And the point that was brought up in terms of
19 best practices and procedures identification is
20 essential and a priority. Published literature as
21 well as a survey of existing programs will help to
22 identify cost reductions that could be expected
23 from intervention programs.

24 So I would almost go back to the
25 recommendations that we made before. It is always

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1 easier to go back to the recommendations before and
2 then tease out something from there and say given
3 what we have heard, can you be more focused and get
4 back to us?

5 DR. GARDNER: This is -- what you have
6 just been talking about is the concept we were
7 trying to put forward in the Armed Forces Unit
8 Production Support Center. That fourth mission is
9 the identification of best practices. The first
10 mission was the surveillance aspect, which is a
11 critical point. And the fourth was the surveillance
12 of the different programs that are out there or the
13 evaluation and review of the different programs out
14 there or the literature review to develop the best
15 practices. The problem we are having is getting
16 resourcing to do that. That is why the cost
17 benefit modeling has come up. Because you have to
18 convince people that it is economically to your
19 advantage to implement prevention -- surveillance
20 and prevention. Because they just don't believe
21 it. They are too busy spending money on airplanes
22 to think about these issues. You know, there are
23 lots of examples of failures. What Dr. Gaydos has
24 described is supposed to happen but often doesn't
25 happen. A good example is during the Gulf War,

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1 they fielded a new aviator chemical protection
2 helmet. Well, somebody forgot that aviators wear
3 glasses and they didn't put lens inserts in those.
4 And it cost a million dollars to suddenly ramp up
5 in a period of a month a contact lens program for
6 the military, which has always been forbidden
7 because they didn't do that. I mean these failures
8 happen over and over and over because we don't have
9 the systems in place for collecting the data and
10 monitoring what is going on to see exactly where
11 the problems are so we can pinpoint them in
12 advance.

13 DR. LAFORCE: Okay. I think that -- I
14 don't disagree with your analysis at all, largely
15 because about half the time when we put a
16 preventive maneuver in place, we don't save money.
17 We just create a better situation for an employee
18 and it ends up costing us something to do that.
19 And there are some times when you do save money.
20 The question that has come up is we don't know
21 whether this is costing money or is going to save
22 money. If the -- and this was the whole purpose of
23 this original discussion. If it was going to be --
24 if it could be shown that we were going to save
25 money, then this was going to be a powerful lever

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1 to get everybody interested and moving in this
2 direction. If it turns out that it doesn't save
3 money, okay. At least it has been shown.

4 DR. GARDNER: But I would argue that you
5 don't save money in the short run. There is an
6 initial investment. But in the long run, if you
7 start looking at the long term disability costs and
8 the productivity costs and away from work and so on
9 -- you get all of that stuff in there -- in fact
10 you generally will save money. And that is the
11 point.

12 DR. LAFORCE: Okay. Well, who wants to
13 take a crack at taking just these four sheets and
14 then creating a response to this that summarizes
15 these concepts?

16 DR. HAYWOOD: Who did it the last time?

17 COL. DINIEGA: Andy.

18 DR. LAFORCE: Andy did.

19 DR. ALEXANDER: I will do that. This is
20 not my field of expertise. I am approaching this as
21 I would approach a dissertation student who --
22 okay, I will do it.

23 DR. LANDRIGEN: Would you put
24 surveillance at the heart of it, though, and put
25 cost benefits as sort of a caboose?

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1 DR. ALEXANDER: Yes, sir.

2 DR. BERG: That would be terrific.
3 Because it seems to have gotten around the other
4 way. They are floundering around trying to come up
5 with these grand schemes and haven't done the basis
6 homework.

7 DR. LANDRIGEN: But I would suggest that
8 in doing the surveillance part of it, if we knew
9 case counts and then you could tease out from
10 worker's comp. The first thing is case counts by
11 job category and also I suspect that there is an
12 upward time trend. There certainly is in static
13 industry in the U.S. But another interesting
14 feature would be to see if you could tease out from
15 the worker's comp data base what is the average
16 cost for carpal tunnel and what is the average cost
17 for a back. And without doing cost benefit, which
18 often evolves into witchcraft, just do the cost
19 side of it.

20 CAPT SCHOR: Yes. I mean I think that is
21 what they wanted.

22 DR. LANDRIGEN: And one question is how
23 good is the surveillance going to be for the
24 civilian side.

25 CAPT SCHOR: People always under-report.

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1 You don't have to worry that it is going to affect
2 it.

3 CDR LUDWIG: I ran an occupational
4 health program in the Army for a couple of years at
5 Fort Drum, New York, and there are enormous amounts
6 of medical surveillance data from the civilian work
7 force that are basically kept in various formats.
8 Now I think things have changed some and I haven't
9 been involved with it for a number of years. I
10 think there is a more centralized system and I am
11 not sure how these data have been transferred into
12 the centralized system. But I know that we had a
13 nurse collecting every month all this information
14 on civilians coming in with various things, and it
15 wasn't being used anywhere. So I think there are
16 enormous amounts of data out there, some of it
17 centralized and some of it not. I think once one
18 goes looking for surveillance data, if you want to
19 concentrate on one installation, for instance, you
20 could probably start a small project or a
21 concentrated project in one area and get a lot of
22 information on one or two different job types.

23 COLONEL STANEK: If I could just
24 comment. I think that is true, but I also think the
25 key there to what you said is for the civilian work

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1 force. For the military work force, that type of
2 surveillance data is not available at this time.

3 CDR LUDWIG: Right.

4 DR. LAFORCE: You see, and I think that
5 was the main message that I got. You remember the
6 last time around when Colonel Lopez presented the
7 famous rucksack story, I thought it was the Marines
8 at Parris Island that specifically jumped into the
9 pond so that they would short-circuit the thing and
10 be able to get rid of it and get it off of them
11 because their back hurt.

12 CAPT SCHOR: Yes, that was the helmet
13 cam kind of thing. And carrying the extra weight.

14 DR. LAFORCE: Yes, that energy source or
15 the battery or whatever it was.

16 CAPT SCHOR: No, that wasn't Marine.
17 That was Army.

18 DR. LAFORCE: Army? Okay. Whatever it
19 was. All I thought of is it is pretty imaginative
20 that a bunch of people diving into ponds to short-
21 circuit something.

22 CAPT SCHOR: I am pretty sure all those
23 type of kits are cruise missile aim points. We
24 don't use those types of things.

25 COL. DINIEGA: But you know, most

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1 disability data is when it ends up in a disability,
2 they know. They know military side who got a
3 disability. They know the civilian side. That is
4 the tip of the iceberg because you don't know all
5 the other ones that never got disabilities. But
6 that is a start.

7 DR. ALEXANDER: There's a cumulative
8 load effect that produces the disability that may
9 not isolate the individual culprit -- the behavior.

10 CDR LUDWIG: There are also many jobs
11 that overlap.

12 DR. LAFORCE: We have got to close this
13 up.

14 CDR LUDWIG: Whether civilian jobs and
15 military jobs, they are basically doing the same
16 thing.

17 DR. LAFORCE: Let's give it a whack and
18 then we will see what happens. The third area that
19 I think we need to make some recommendations -- and
20 this is the chlamydia area.

21 DR. ALEXANDER: I'd be happy to work on
22 that one.

23 DR. LAFORCE: Okay. And in thinking
24 about this, what I would like to do is just sort of
25 put something down on the table, which -- and this

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1 is the disease burden issue. Because whenever we
2 initiate a discussion -- for example, Charlotte's
3 point as she goes around and says, look, every
4 single individual who is an asymptomatic carrier,
5 30 percent of them are going to have an attack of
6 PID within a year. I am like this and I am saying,
7 first off, how true is that? I don't know, I am not
8 that based, one. And two, if it is true, there
9 ought to be plenty of data in the military on the
10 basis of what are the attack rates of PID given the
11 prevalence rates of chlamydia that are coming in if
12 you look at a base, for example -- I have forgotten
13 the name of the fort in Georgia -- Fort Jackson, I
14 thought it was, wasn't it? And so one of the
15 things that I thought that might help illuminate
16 this rather than -- would be sort of a request then
17 to actually see whether there would be a way of
18 looking at the issue of disease burden as a way of
19 accelerating -- as a way of helping define it.

20 DR. HAYWOOD: Some of that has been
21 presented in the past, so there are data within the
22 military.

23 DR. LAFORCE: Not the PID data. I don't
24 remember --

25 DR. HAYWOOD: The complication rates

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1 represent it.

2 COL. DINIEGA: Specific military rates?

3 I think the rates that have --

4 DR. HAYWOOD: That is my recollection.

5 COL. DINIEGA: Yes, I don't recollect
6 military rates.

7 CDR LUDWIG: May I comment on that?

8 COL. DINIEGA: Sure.

9 CDR LUDWIG: From the point of view of
10 the STD prevention committee, which the
11 surveillance and epidemiology subcommittee is my
12 committee. We have made a lot of progress
13 basically determining what it is we need to do.
14 And Dr. Gaydos is on the committee as well and has
15 contributed a great deal of information basically
16 showing us that we have -- the only prevalence data
17 we have in the military are the collection of the
18 bibliography that he has provided. The only
19 prevalence data that we have in any part of the
20 military population. We could do a DMSS DMED
21 request and find out how much PID there is out
22 there, but it is not going to tell us if it is PID
23 related to a sexually transmitted disease or -- I
24 mean, there is no specificity.

25 DR. LAFORCE: The vast majority of PID

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1 in individuals that are less than 25 are due to
2 sexually transmitted diseases.

3 CDR LUDWIG: Nevertheless, what I am
4 saying is we can't get any association. There is
5 not a lot of association we can get with how far
6 out that is from an infection with chlamydia or --
7 what I am saying is we can find out how much PID
8 there is, but there is --

9 DR. LAFORCE: All I was trying to do --
10 please -- was not a \$5 million study that is a
11 prospective study. All I was saying is if you have
12 a 10 percent prevalence rate and you have X number
13 of people that are coming in that are really not
14 screened, if that 10 percent is at a 30 percent
15 risk of PID within a year, then it is 10 times .3
16 equals some sort of number. And my question is does
17 that number come anywhere near what it is that you
18 actually see? It is no more complicated than that.

19 DR. ALEXANDER: Well, it is in the sense
20 that not all PID is in-patient PID.

21 DR. LAFORCE: Oh, no, no. But it is
22 coded whether it is outpatient or inpatient.

23 DR. ALEXANDER: If we could do out-
24 patient and in-patient coding for PID, ectopic
25 pregnancy, that would be a good measure. The other

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1 measure I was thinking of yesterday trying to do
2 something that would be inexpensive -- a quick and
3 dirty assessment of just what are we doing.

4 Because we are getting reports that, oh yes, we are
5 doing it, we are just not counting it. It would be
6 to do a surrogate measure of, okay, well how many
7 rapid tests, non-invasive urine-based tests are you
8 using and let's look at the population and that
9 would give us another measure. Are we anywhere in
10 the ballpark of screening reproductive age women on
11 an annual basis given that volume of usage. Or
12 what is our prescriptive medication count in terms
13 of the drug of choice for managing chlamydia. So
14 those would be other surrogate measures that would
15 at least give us a handle on whether or not we are
16 in the ballpark of managing chlamydia now because
17 we don't have the epidemiological data to make that
18 determination.

19 DR. LAFORCE: My point was that if, for
20 example, you go through the data base that includes
21 both ambulatory as well as hospital PID and it
22 turns out that the rates of disease are much lower
23 than you would have predicted given these
24 epidemiologic criteria or these clinical criteria,
25 then I would start asking myself the question.

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1 Wait a second. What is the beef? I mean, where
2 are we in terms of this? And it may be a bit more
3 complicated than saying, well, we start off with
4 the universe and we multiply by .3 and we know that
5 bad things are going to happen. That may be true.

6 That may not be true. I think there might be a
7 simple, quick and dirty way of actually looking at
8 that. Now it may make -- it may be that it is
9 easier to answer or wrestle with the question in
10 terms of even a race specific question. Because we
11 know carrier rates are higher in blacks than
12 whites, and you might be able to sort of sit down
13 and look at these just with the information that
14 you already have from Dr. Gaydos's epidemiologic
15 studies. That is all. Yes, David?

16 DR. ATKINS: I am not entirely clear
17 what exactly that -- whether that data is going to
18 be the determining factor or not. I mean I guess --
19 it seems like we are on record as supporting
20 chlamydia screening at accession, but recognizing
21 that there are some logistical problems in the
22 different services in doing that.

23 DR. LAFORCE: Correct.

24 DR. ATKINS: And it seems like one of
25 our concerns is that what we said in our

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1 recommendation was that, however, because of these
2 logistical concerns that screening over the next
3 year is acceptable. It seems like what we don't
4 have -- the data that we don't have but should be
5 able to get at is is that happening. And my feeling
6 from the discussion yesterday is I don't think the
7 military is doing any worse than the civilian
8 sector, but I think that they are probably both
9 doing equally badly in making sure that that
10 screening in the context of usual care always
11 happens. So could we request just data to say from
12 a limited sample of chart reviews to say that among
13 100 recruits who were not screened at accession,
14 what is their likelihood of getting screened over
15 the next year? How many of them actually go in for
16 a pelvic exam, and of those that do, how many of
17 them actually get the test that the clinicians are
18 saying that they are doing. If we are finding that
19 it is only 20 percent, then that gives us a little
20 extra reason to say you need to push harder on
21 making it happen at accession. If it is happening
22 within the context of a year, then you have that
23 separate question, how much are they suffering from
24 the fact that they didn't get it in those 12
25 months. I agree with you that I don't think we

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1 really know what the true attack rate on a
2 prevalent case is. But I am not sure that if it is
3 10 percent or 30 percent

4 -- maybe that will make a big difference.

5 DR. LAFORCE: Oh, I think it makes a big
6 difference. Because if it is 30 percent, those are
7 medical costs that are being borne because of the
8 absence of a screening test and treatment. So there
9 are real savings that are involved. That is why the
10 quick and dirty approach in terms of saying if
11 those rates of PID, either ambulatory or hospital-
12 based PID, are as high as we were told, I think
13 this would be pretty persuasive. Because it is
14 costing the Army. It is costing a lot of money if
15 those rates are actually that high.

16 DR. HAYWOOD: There is a cost to the
17 human being too.

18 DR. LAFORCE: Yes, of course. And I am
19 not -- but again, we are coming down to this -- the
20 recommendation at accession is there. But one of
21 the difficulties in implementing that is that the
22 Army did not have a PAP smear strategy in place,
23 unlike the Navy. So, therefore, with the Navy
24 testing at accession, it was pretty easy because
25 they were already doing something.

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1 DR. ATKINS: But we don't need a PAP
2 smear anymore.

3 DR. ALEXANDER: We don't need a PAP
4 smear. We can use urine.

5 DR. LAFORCE: No, no, no. I am not
6 saying PAP smear. All I am saying is that with the
7 Navy, there was already an accession pelvic that
8 was part of that. Whereas --

9 DR. BERG: Opportunity.

10 DR. LAFORCE: That is right. So it is
11 just the opportunity, whereas with the Army that
12 was not the case.

13 DR. ATKINS: But I think we need some
14 feedback from the service folks as to are the
15 obstacles at accession -- do they think they are
16 sort of temporary and they will eventually get to
17 universal screening at accession? Are they costs
18 in which some cost data might convince the people
19 who are hesitant about investing in the cost of
20 adding something to accession. Or the time issue --
21 even peeing in a cup is a logistical issue that is
22 hard for them to get around. I mean, I don't know
23 what data can be helpful.

24 DR. GARDNER: I can tell you it is a
25 cost issue. We went through this with the sickle

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1 cell trait testing a few years ago. They refused
2 to even consider doing the sickle cell trait
3 testing at the MEPS stations, military entrance
4 processing stations, because only two-thirds of the
5 people who go through there eventually get
6 accessed, and that means it increased their cost by
7 50 percent. So then they said, well let's try doing
8 it at the bases, which is much more difficult
9 logistically, but it saved money. So if you are
10 going to save money, nobody is going to consider
11 the alternative.

12 LTC RIDDLE: One thing I want to say is
13 -- I am just trying to think about this. Why -- I
14 am asking myself why do we thrash around with
15 chlamydia in trainees? We don't look to make any
16 other preventive intervention except immunizations
17 in trainees. We don't look to screen trainees for
18 anything else. We have a system to check out the
19 fitness of recruits. We bring them in and we train
20 them and then we go forward and we have a medical
21 system to take care of their ongoing needs. I am
22 just trying to ask myself why is this different.
23 There may be good reason. I mean there may be an
24 epidemic out there of expensive and epidemic
25 proportions that would require drastic or targeted

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1 action for one disease entity. But I would like to
2 kind of know the -- then maybe you know how did
3 this come up? I see where General Kiley asked the
4 question, but I don't really think that is the
5 answer. I mean how did this issue surface? I mean
6 why not screen them all for sickle cell anemia?
7 The answer to that is, well, we do that at the MEPS
8 station. We do that at the MEPS physical. Okay, so
9 -- then what I am getting to is why don't we do
10 this in MEPS? Joel, maybe you can -- I am really
11 not trying to -- I really just want to know why
12 this? Why is this special? Why can't we deal with
13 it in the regular process, which is to have a MEPS
14 physical and deal with this and then say to the
15 person, well, you have got to go back and get
16 treated by your doctor and you are not set to come
17 in until you do this.

18 COL. DINIEGA: I think that was one --
19 at least it was voiced that that would be one of
20 the alternatives, to have it done sometime before
21 accession -- during the MEPS process. And then the
22 question was could that be worked out. I mean, I
23 think if the Army wanted to pursue that, you would
24 have to work it out with MEDCOM. But I think John
25 is correct in saying that it would be a lot of

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1 money for them and who is going to come up with the
2 money. I mean, that is a way to do it.

3 DR. ATKINS: A lot of money if it is
4 done through MEPS?

5 COL. DINIEGA: Because they only access
6 a small few.

7 LTC RIDDLE: No, MEPS doesn't do that.
8 MEPS job is to determine fitness not to render
9 medical care. In the case where we might take the
10 approach of well you are unfit -- you are welcome
11 to join, but you've got to come back with a
12 negative urinalysis. You have got to go to your
13 doctor and pay this for yourself and then come
14 back. Now there are deficits for doing it that way
15 as well. But, again, I keep getting back to my
16 point. Why do we treat this case different? It
17 may be different. But we do have a mechanism to
18 check out the fitness of soldiers as they come in
19 and to screen out the unfit and let in the fit.

20 DR. LAFORCE: I think it is the disease
21 burden and also the fact that this is an infectious
22 agent and people have intercourse. There are two
23 issues. One, there is a clinical issue to that
24 individual who is asymptotically infected. In
25 other words, what is the disease burden. And also,

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1 sex occurs and this is an infectious agent that
2 gets passed around. So there are a couple of
3 things.

4 LTC RIDDLE: The same could be said of
5 syphilis.

6 DR. LAFORCE: Oh sure. But this is a
7 lot more common.

8 LTC RIDDLE: I am just trying to
9 contemplate this disease. I kind of know the
10 answers. But again, why don't we test every basic
11 trainee for syphilis.

12 DR. ALEXANDER: Or herpes.

13 LTC RIDDLE: I mean, we could go on and
14 on and on. I mean, why chlamydia?

15 DR. ALEXANDER: I'd like to come back to
16 -- I would like to answer your question about
17 chlamydia. I think it is a no-brainer. The cost
18 benefit analyses have been done, in fact even
19 specific military cost benefit analyses have been
20 done. Chlamydia is an infection that is
21 ubiquitous. It is easily treated. It is easily
22 diagnosed. The adverse outcome are so undesirable,
23 particularly in terms of women's health. That with
24 an early intervention, we can do something that is
25 really producing a soldier, male or female, that is

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1 not infectious. That is important in a military
2 environment. As a public health person, I am
3 having trouble just even trying to defend this
4 because it is so intuitive, it is so logical. This
5 is a case where we can make a profound difference.

6 We have been successful at the national level
7 getting this implemented in prisons and underserved
8 populations of women in managed care, and it seems
9 odd that we are having to fight for it to be
10 available in the military. That is the part that
11 seems like such a major disconnect to me. If we
12 have to do it, let's do it. And if there aren't
13 military resources to do it, then let's be creative
14 and utilize some of those outside resources so that
15 the people in the military don't have a chlamydia
16 burden. It is a very easy thing to justify from a
17 public health perspective.

18 DR. LANDRIGEN: A thread that seems to
19 be running through this that we haven't addressed
20 explicitly is the question of what is the frequency
21 -- what is the optimal frequency of testing. I
22 mean, one option is to do it a single time at the
23 time they do their intake physical. But as Marc
24 says -- he doesn't have any data to prove it -- but
25 people probably do have sex. And therefore, there

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1 are subsequent opportunities for passage. So the
2 question arises, should it be done monthly, three-
3 monthly, six-monthly, annually, just once?

4 DR. ALEXANDER: Well, the CDC has made
5 recommendations to that effect. Annual screening
6 of reproductive-age women 15 to 25 is recommended.

7 That is whether you are in a publicly funded
8 clinic, a prison, a Planned Parenthood clinic or --

9 DR. LANDRIGEN: Just women?

10 DR. ALEXANDER: Well, right now.
11 Actually both were in the guidelines. The most
12 recent one has made funding available for women.
13 This year, as we go back to Congress for funding,
14 we are asking for funding for male screening as
15 well. You know, we are trying to put the
16 infrastructure in place to make the funding
17 available to cover this. We could essentially
18 eliminate chlamydia if we had an aggressive
19 national program. And we could prevent -- you know,
20 half the infertility in the U.S. is attributable to
21 chlamydia. And those bills are enormous.

22 DR. LANDRIGEN: So you would be
23 advocating that it be incorporated in the intake
24 physical and then repeated annually thereafter?

25 DR. ALEXANDER: I am advocating that we

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1 make the population in DoD -- let them have access
2 to the same treatment standards that women in
3 civilian settings have. Now how that is done -- I
4 am not going to argue whether it should be done at
5 MEPS or whether it should be done at basic training
6 or AIT. But there should be annual access of women
7 in the military to chlamydia testing.

8 DR. ATKINS: And we don't know that that
9 is not happening.

10 DR. ALEXANDER: Right.

11 DR. ATKINS: So I think the first step
12 is to request the data to address that. And then -
13 -

14 DR. BERG: There are a couple of points
15 that I would like to make. I mean, we had two
16 presentations on military medical history. STDs
17 have always been a burden in the military. I mean,
18 there has been a lot of moral overtone to it too,
19 but they have always been a burden. And now when
20 we are looking at career forces, it is not just the
21 treatment cost, it is the cost of active duty
22 people who can't get pregnant and want to find out
23 why and what they can do about it. STDs have
24 historically been one of the major disease burdens
25 of the military. And now we have the tools and the

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1 techniques to involve the males too. There was
2 always -- screening for males has always been a
3 good idea, but it is really hard to get some guy
4 who is going to let you stick a swab up his crank
5 if he is not symptomatic. Now with urine-based
6 testing that is very good, we can get around that
7 and we can attack both ends of the problem so we
8 don't ping-pong it back and forth.

9 To shift gears a little bit, at this
10 stage of the game I am a little confused as to what
11 the issue is here. Are we trying to restate our
12 recommendation for chlamydia testing? Are we
13 trying to say this has fallen on deaf ears and what
14 do we need to do to strengthen the recommendation?

15 Do we need to get data? Or are we really trying
16 to figure out where the best time to do this is?
17 Is it the MEPS? Is it recruit training? Or is
18 after that? Or is it all three of those questions?

19 LTC NEVILLE: Sort of all three. But
20 speaking for the Air Force -- I am not representing
21 anybody but my own office, I suppose. But
22 everybody, clinicians as well, accept those
23 recommendations to screen annually, 15 to 24 or
24 whatever. And I have to say again that I think
25 that probably happens in the Air Force. I can't say

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1 that. But that would be relatively easily
2 obtainable data that we could bring back to the
3 next Board meeting if you want to know that.
4 Because the lab that does most of those things for
5 the Air Force is co-located with me and that would
6 be relatively easy to do. Chart reviews may be a
7 little bit more of a problem. Pardon me?

8 CAPT SCHOR: Do it for the Army too?

9 LTC NEVILLE: Well, we might actually be
10 able to do that. But it would be easy to do the
11 PID or the disease burden issue or relatively easy
12 with DMED -- ambulatory or in-patient or whatever.
13 That is quick and dirty.

14 DR. GAYDOS: That is the problem. It is
15 dirty. That is the point that we need to make.

16 LTC NEVILLE: Right.

17 COL. DINIEGA: But if the answer is --
18 well, are you saying no answer will be acceptable?

19 DR. GAYDOS: Can I just maybe go back
20 and try to answer some of the questions that have
21 come up? First of all, I would like to point out
22 that there is a chlamydia epidemic in the United
23 States. It is extensive. There have been extensive
24 studies done with regard to civilian populations
25 which were comparable to the ones we see in the

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1 military. And there has been at least one study
2 that has shown that one hit in terms of screening
3 and treating will reduce your PID significantly
4 over the course of a year. When this got started
5 about 1994 or so, we looked at the in-patient rates
6 for PID and ectopic pregnancies for the Army. They
7 were -- I can't remember the number, but they were
8 just incredibly higher than what was reported for
9 the civilian world. I mean, they were extremely
10 high. And my understanding of what occurred at that
11 time was that the Navy took the data and
12 information that was available on chlamydia and
13 took the position that when we released a trainee
14 to the Navy from basic training, we want that
15 trainee to be as physically and as mentally fit as
16 they can be because they are going to be sent
17 places in the world where the level of medical care
18 is not uniform. The opportunity to go in for
19 periodic exams and a whole lot of things are
20 different. So we want that individual to leave
21 Great Lakes in the best mental and physical
22 condition that we can. I am trying to tell you
23 what Commander Ryan said as far as what was going
24 on at that time. So they decided based on what was
25 available at that time to screen men and women and

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1 to treat men and women. No we can disagree with
2 the sensitivity of the test they used, but
3 nevertheless that was their approach and that is
4 what they did. Somewhere along the line this came
5 into the Marine Corps too. I don't know when the
6 Marines got involved with this.

7 Now with regard to the Army, these very
8 high rates were part of the package that went
9 forward and resulted in the funding for this study.

10 Now what has happened is that -- and Dr. Stanek I
11 hope will be able to comment on this -- I think
12 going from the early 1990's, when we had a much
13 more liberal policy for admissions to now, we don't
14 really know what is happening out there with regard
15 to treatment of PID or even ectopic pregnancy. And
16 I don't have a lot of confidence in the outpatient
17 data as it is coming in right now. So my feeling
18 is, and we have looked at this, is that we really
19 would have a pretty difficult time at this point in
20 time going in and taking what is available in terms
21 of inpatient and outpatient and characterizing what
22 the experience is with regard to PID and even
23 ectopic pregnancy out there in the services. The
24 situation is that there is a lot of anecdotal
25 information out there from people who are working

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1 with women in the field that women in uniform are
2 being placed in a lot of positions where the
3 standard of medical care as we know it here in the
4 States or that we expect to be practiced here in
5 the States is not available to them. If you are
6 out in the desert somewhere or you are someplace
7 else, it is not that easy. A lot of people come
8 back -- and I am not just talking about the Army --
9 I am talking about the other services also -- and
10 said in talking to these women, number one it is
11 not convenient a lot of times to go out there and
12 do this. Number two, if you are going to -- if you
13 are out there with a medical unit, then you become
14 very well acquainted with all the people in that
15 unit and sometimes these women are not going to
16 come in to medical care for something like a GYN
17 problem because they know the people in the unit
18 and they are reluctant to do that. I have
19 received this from a lot of people, and it is also
20 not convenient. And in a lot of places in the
21 world, the story that we get back is that if a
22 woman comes in and she has any significant genital
23 type complaint, she is probably going to get
24 evacuated because an examination won't be able to
25 be done. So there is this concern about the

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1 standard of care that is actually going on out
2 there.

3 What has happened now is I will tell you
4 that based on these types of things, the Department
5 of Defense has given considerable money -- for
6 example, the University of Pittsburgh has received
7 a lot of money. The University of Pittsburgh has
8 actually been working on self-treatment kits.
9 These are self-treatment kits for women and the
10 proposed use is that for certain types of symptoms,
11 in the absence of a fever, in some of these areas
12 they would be able to use these kits. The
13 Department of Defense has also funded studies to
14 look at diagnostic alternatives such as the SAS or
15 self-administered swab, where a women who may not
16 be able to go into the clinic and be able to be put
17 up into stirrups and have the type of examination
18 that we are accustomed to seeing, but would use the
19 self-administered swab which could then be sent off
20 to the laboratory and tested. So there is a --
21 there are different standards of care throughout
22 the world for people in uniform, and particularly
23 women in uniform. And I don't have confidence at
24 this point in time in the outpatient data to look
25 at what is happening. I think without the

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1 outpatient data, we are at a great loss the way
2 that we are developing a managed care system in the
3 military to say that we can really characterize
4 what is going on with regard to PID and ectopic
5 pregnancy.

6 DR. BERG: How do you feel about the
7 outpatient data from major medical centers like the
8 big Army posts. I can see certainly on a deployment
9 that these factors would be operable. Are they
10 likely to be operable at a major military post or
11 even though they are outpatient, many of these
12 objections would not been there.

13 DR. GAYDOS: Colonel Stanek is from the
14 Defense Medical Surveillance Center.

15 COLONEL STANEK: I guess my concern with
16 that is when we saw the ADS bubble sheet that are
17 used for the surveillance and how they collect the
18 data. Part of the issue there is how it is coded.

19 I think getting back to what was said earlier, we
20 don't have a clear indication of this screening, if
21 it is going on and if it is taking place during the
22 year after they finish their recruit training. If
23 someone gets coded as chlamydia, the question is do
24 they come in for chlamydia and be treated, if that
25 was what the diagnosis was, or did they come in

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1 because they were in contact with chlamydia and got
2 treated. Or did they come in and was that just
3 part of the screening. When you are at our level
4 when we are just getting that data, sometimes it is
5 hard to answer that question. I think it is a
6 question -- to really answer this question
7 correctly, we need to answer the question -- ask
8 the question of what is going on at the MTFs in the
9 year after they finish their accession and after
10 they finish their training. And then we can more
11 better quantify if this is really a problem. I
12 agree with Dr. Gaydos. I have some concerns with
13 the ambulatory data. It is better than it was
14 three, four or five years ago, but it is not where
15 I would like for it to be. Hospitalizations are
16 going down, but that is true across the entire
17 nation within managed care. We are treating more
18 as an outpatient. So some of the things that we
19 would like to know to answer this question may be
20 hidden and we may need to ask some second level
21 questions to get a better answer.

22 DR. ALEXANDER: And it is problematic
23 with chlamydia given that 75 percent of women are
24 asymptomatic.

25 COLONEL STANEK: Exactly.

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1 DR. ATKINS: But not if we are defining
2 the issue as PID.

3 DR. ALEXANDER: Right. Right. Which
4 disease burden.

5 CAPT SCHOR: Just real quickly, I would
6 just suggest from a Navy and Marine Corps
7 standpoint that the Bureau of Medicine and Surgery
8 has a women's health code that is staffed by a
9 nurse practitioner and very capable staff and has
10 board meetings. And they look at a lot of different
11 things. It is code O2W, women's health. They look
12 at deployment health. They look at the issues of
13 presentation. They have commissioned surveys. They
14 have a budget. They have the power to get people to
15 do things and look at things. And I am sure they
16 have looked at a lot of this -- practice guidelines
17 and implementation and a lot of these issues. So
18 at least in our side of the fence, they probably
19 have a lot of these answers so that we don't have
20 to go and reinvent the wheel. I don't know that
21 absolutely for sure, but they are heavily engaged
22 in this whole area and have gotten great support
23 from the Surgeon General and from the folks out in
24 the field.

25 DR. LAFORCE: Questions?

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1 LTC NEVILLE: Just two things. One is
2 from an Air Force point of view, I don't have any
3 problem at all accepting the AFEB recommendation
4 for screening at accessioning. The only problem is
5 that I don't control that and it is hard to
6 implement in the vacuum of the medics. We can't
7 just do that. So I would like to and want to and
8 am going to try to do that.

9 The other thing is at least in the Air
10 Force anyway in the last year, there has been a lot
11 more emphasis from the MTF commander level or
12 provider level for cleaning up the data of the
13 ambulatory coding. That is a complete separate
14 issue, so I have a little bit better confidence in
15 the Air Force ambulatory codes now than I did a
16 year ago. I am not sure about the other services.

17 DR. GARDNER: A point of order. Where
18 in the accession process does the screening for
19 syphilis and tuberculosis occur? It seems like it
20 is analogous.

21 DR. ALEXANDER: MEPS.

22 LTC NEVILLE: Those get done in the Air
23 Force the weekend they step off the bus.

24 DR. ALEXANDER: They screen for
25 syphilis?

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1 CDR LUDWIG: MEPS screens for TB.

2 LTC NEVILLE: Well, by history TB.

3 DR. GARDNER: The skin test and the
4 syphilis serology -- I assume the skin test and the
5 syphilis serology are done -- I am sorry -- at the
6 initial step or later on after they are in?

7 LTC NEVILLE: For the Air Force, when
8 they arrive at training at Lackland Air Force Base
9 that first weekend.

10 DR. GARDNER: Okay. So it is not when
11 they are at the recruitment center?

12 LTC NEVILLE: They may get it at the
13 MEPS station. I am not sure.

14 DR. GARDNER: We need somebody from
15 AMSARA to tell us more about what MEPS is currently
16 doing. But when I was looking into it a few years
17 ago, they don't do chest x-rays and they don't do
18 CBC's. The only reason they draw blood is for HIV.

19 I mean the big HIV issue was the first time they
20 started drawing blood. I don't think they even do a
21 urinalysis.

22 DR. GAYDOS: I don't think they are
23 doing syphilis serology.

24 DR. ALEXANDER: I don't think so either.

25 DR. GARDNER: That was one of the things

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1 that AMSARA looked at and the cost benefits were so
2 low that I think that was dropped because it was
3 thought that whatever positives would come through,
4 they would be picked up on their other physical
5 exams.

6 DR. GARDNER: They screen for everything
7 by history and a brief physical.

8 DR. ALEXANDER: In an effort to sort of
9 focus on what it is we might do, I thought maybe we
10 might as the Board ask two questions for the
11 services to report back next time. One might be
12 could we clarify the disease burden? Do we have
13 any kind of profile on what the adverse outcome
14 associated with chlamydia is, as best as can be
15 determined in a quick and dirty assessment looking
16 at in-patient and out-patient data bases with PID
17 and ectopic pregnancy. Just what do we know? That
18 might be one question.

19 The second question would be what is the
20 current screening picture for chlamydia in the
21 services? What are the policies that are in place
22 and then what sort of surrogate measures could be
23 presented that would paint a picture of what is
24 currently happening, whether it is a survey of
25 practitioners that could be done in a quick and

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1 dirty way or whether we count the number of
2 diagnostic units that were dispensed or the number
3 of treatment courses that were dispensed. But just
4 paint a picture as best we can of what is going on
5 now. If we were tasked to present, okay, what is
6 happening in the Coast Guard with chlamydia
7 screening, how could you go about doing that? Not
8 limiting your parameters. Use your creativity and
9 come back and report. And maybe based on that
10 feedback at the next meeting, we could be a little
11 more focused in our recommendations.

12 DR. LAFORCE: David?

13 DR. ATKINS: And I would just add as a
14 third thing some discussion of the specific
15 barriers within each service to doing screening at
16 the -- not at MEPS, but I guess at the basic
17 training or whatever and what the barriers that
18 they are facing are.

19 DR. LAFORCE: Bill?

20 DR. BERG: I would add on that the
21 apropos of the discussion here that the report
22 should include some sort of discussion of their
23 level of confidence in the figures. Because I have
24 heard doubts raised about it, but I haven't heard
25 any of the doubts raised to the level of saying

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1 forget about it, it is not worth the effort. Or do
2 any of you want to jump in and -- I hear a lot of
3 qualifiers and hesitancy, but I don't --

4 LTC NEVILLE: It is hard to judge the
5 accuracy of the data because it is all -- unless
6 you did -- it is five minutes to do the search on
7 the data base. The DMED does that and you are done
8 in five minutes. But the accuracy of that
9 ambulatory data, you would have to do some -- do
10 that search and then go into the records and see if
11 it actually reflects the visits -- the medical note
12 matches the code that was given for that visit, and
13 that is a much harder thing to do.

14 DR. BERG: That sounds like a wonderful
15 idea.

16 DR. LAFORCE: Except that again, looking
17 at the question, one of the advantages of looking
18 at data within the military is that no matter how
19 sort of flawed it may be, it is not 100 percent
20 flawed. It just isn't. So there is going to be, you
21 know, the bell shaped curve that is going to go
22 around. But making the presumption that it is not
23 useful -- that is a little tough for me. You know,
24 I would make the presumption that gee we ought to
25 make the presumption that it might be useful.

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1 DR. GAYDOS: If I may comment. Some of
2 us feel that bad or questionable data is worse than
3 no data. I think that the problem is you heard
4 yesterday from Dr. Pavlin about people who just
5 stopped reporting. I think there are a number of
6 people in this room and there was somebody who
7 mentioned something yesterday about people just
8 checking off a box to get the requirement over with
9 and reporting something. There is a lot of that
10 going on. And I think we appreciate that. We don't
11 know how much and we don't know where. And I am
12 going to remain very skeptical and hesitant to
13 place any confidence in those data until there is
14 some audit to say exactly what is happening in
15 terms of what percentage is being reported or not
16 reported and what is being reported correctly or
17 inappropriately. I think that is what has been
18 done. And you folks have done some of that, right
19 Scott? You conducted an audit of some of your
20 reporting.

21 COLONEL STANEK: That was with the
22 reportable events..

23 DR. GAYDOS: These were reportable
24 events. And do you recall what percent of
25 reportable events were being reported?

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1 COLONEL STANEK: We compared it to
2 ambulatory data. So we are up to now I think 60
3 percent of compliance.

4 COL. DINIEGA: Which was the gold
5 standard.

6 COLONEL STANEK: This is the question.

7 DR. BERG: I wasn't trying to say we
8 should not do it. But I think it is appropriate to
9 get some idea of the evidence. Because the danger
10 is we descend into epidemiological nihilism. We
11 don't have perfect data, so we are not going to
12 look at it. We don't make any progress.

13 DR. LAFORCE: Okay. We've got a couple
14 more. Yes?

15 DR. ENGLER: Just from the clinical
16 perspective, the ADS systems in terms of the bubble
17 sheets inserted into our system which adds four to
18 ten minutes check-in time, you can't in a clinic
19 actually reflect all the diagnoses that you see.
20 We have no help like in a group practice where
21 somebody is helping us develop strategies for
22 coding. In a clinic, you really need three
23 different sheets because you are limited with
24 diagnoses. What the sheets do is they make a
25 decision about a blank and generic one that happens

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1 to fit. I can tell you stories like the Chief of
2 Neurology in his frustration just said, I don't
3 care. Code it all prostatitis and the hell with
4 it, pardon my French. I think the problem -- and
5 people are, I think, this year making some efforts
6 to do strategies for a compromised improvement so
7 you are at least in the ballpark as a system. But
8 I think you heard yesterday, code it all as fever
9 or do whatever. Just whatever day you look at,
10 you've got to understand it could be from 25 to 50
11 percent wrong and garbage in is garbage out or
12 more. And there is no administrative
13 infrastructure support like in any private practice
14 within our system for doing this work. And there
15 are very few people in many of the smaller clinics
16 who even have somebody who is willing to sit down
17 with the coding book and try to structure it. It
18 is not like there is a massive army of preventive
19 people reaching out to bidirectionally work with,
20 hey guys, you could help us if you do this or that.

21 There is a lot of smoke and mirrors even though
22 the service representatives get up and say, oh yes,
23 we have this system and we are collecting data. It
24 is just like with the immunization tracking from
25 any of the services. I can tell you from a clinic

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1 perspective, it is 25 to 40 percent of the time
2 absolutely wrong. There is duplicate stuff and
3 people are marching happily along and saying,
4 aren't we wonderful, we are doing this tracking.
5 That doesn't mean that some data isn't at least
6 useful, but please put in big letters plus or minus
7 and the range may be bigger than 50 percent. And it
8 could lead you to wrong conclusions. And again, the
9 illustration of PBD's, where they were talking
10 about, oh, we need to treat people with BCG and I
11 brought up the point that we have documented that
12 people are giving PBD's, typing in negative and
13 telling a person if you see something come back.
14 So I said your baseline PBD levels are totally
15 unreliable. So you cannot make any assessment of
16 the need for BCG until we really try to train
17 people to at least have the basic knowledge of
18 doing the test correctly. Again, just understand
19 the clinical perspective. It is not because
20 clinicians don't care or that they don't want to be
21 part of the process of improvement in identifying
22 issues. But this Board needs to also recommend
23 that there has to be some reality look at what it
24 takes to do the work to do the correct data
25 capture. Everybody is pretending that that happens

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1 out of the ether and there is a no cost solution,
2 and that is not what is going to be happening in
3 reality.

4 DR. GARDNER: I think you have in the
5 military very dedicated health professionals who
6 take good care of their patients. But there is no
7 -- very little system support to provide for the
8 data collection process. And frankly, they only do
9 what they absolutely have to do in that respect.
10 They are very meticulous at coming up with the
11 right diagnosis and doing the right treatment and
12 making sure the person is taken care of. But what
13 goes on the reporting record is extra work that
14 they want nothing to do with and they are going to
15 simplify it as much as possible. Right now, they
16 are being forced -- they are counting visits in
17 terms of staffing and manning, so they are being
18 forced to turn in something. And in order to
19 account for actually how many patients they see,
20 but there is nothing that coerces them to put the
21 correct diagnosis on the sheet.

22 DR. LAFORCE: Does the military have any
23 sentinel sites? This problem is not unique only to
24 the U.S. military. Many other facilities have
25 usually sprinkled within systems what are called

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1 sentinel sites where they have invested more in
2 terms of resources so that you have got at least
3 some comparison.

4 CAPT SCHOR: No.

5 DR. LAFORCE: No? Okay, thank you.

6 LTC NEVILLE: I will say, though, in the
7 Air Force within the past year -- and this is maybe
8 way off the topic of chlamydia screening -- but
9 there is a whole big emphasis and investment in
10 primary care optimization. And every single MTF
11 sends 8 to 10 people to a training thing for a
12 week-long, and this is one of the biggest of the
13 thing, garbage in/garbage out and they have to
14 manage their populations and on and on and on. So
15 I feel a lot more confident with Air Force
16 ambulatory coding today than I did one year ago. I
17 said that already. And if it please the Board, we
18 can look at the Air Force data. I don't have the
19 resources to say we will go to the MTF and do chart
20 reviews and verify that stuff, but I can try to get
21 some kind of a sense from a sister organization,
22 Brooks Air Force Base, that is doing that, going to
23 the MTF's. Just some sense of how accurate that
24 stuff is. We can get this stuff from the ambulatory
25 DMED for the Air Force anyway and just present that

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1 for what it is worth.

2 DR. LAFORCE: Okay. We've got to close
3 this.

4 DR. BERG: I was just going to say I
5 think we need to send a question to the services
6 asking for the three that Linda said. Asking for
7 the information so we can move forward on this, not
8 --

9 DR. LAFORCE: Linda, can you draft
10 those? The three questions that we talked about?
11 In other words, what is happening in terms of
12 screening? How often -- in other words, that was
13 your report card is what you are asking for, right
14 David?

15 DR. ATKINS: Right. Some sample.

16 DR. LAFORCE: Yes, what is happening.
17 That is point one. Point two, are there any data
18 using whatever -- reporting data. Perhaps it is
19 better for the Air Force than the Army. I have no
20 way of knowing. But at least some sort of idea as
21 to clinical burden. And I have succeeded so well, I
22 have forgotten the third point.

23 COL. DINIEGA: One was the disease
24 burden. One was compliance to female recruits
25 getting a chlamydia screening and a PAP smear

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1 within the first year of enlistment. And third was
2 the specific barriers to recruit screening
3 implementation.

4 DR. LAFORCE: Barriers.

5 DR. ALEXANDER: We added a fourth, which
6 was just a comment on the confidence in the quality
7 of the data.

8 DR. LAFORCE: Okay.

9 COL. DINIEGA: Right.

10 DR. HAYWOOD: And problems with
11 screening.

12 DR. ALEXANDER: And problems. That is
13 correct. Thank you.

14 DR. LAFORCE: It is nice to be clear.

15 DR. ALEXANDER: I need a list.

16 DR. LAFORCE: Okay. The next item that
17 I have on the list is I hate to say this, but it is
18 adenovirus. Oh, thank you for this raucous
19 laughter. I am just going to ask the Board whether
20 it is worthwhile -- Ben, what do we have, 11
21 statements that were made?

22 COL. DINIEGA: No, we have a statement
23 in 1995 and a statement in 1998. 1995 was when
24 they were beginning to get threats of shutting
25 down. 1998 was when obviously the company was

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1 going to shut down and we had limited stocks
2 remaining and how we should best use it. And then
3 again endorsing the continued availability of the
4 vaccine. None since 1998. However, what I would
5 like to say at this point is besides the Institute
6 of Medicine committee that is looking at endemic
7 disease vaccines in the military, which Dr. Pahland
8 and Dr. LaForce are members of, and they are having
9 a meeting Thursday and Friday of next week and many
10 of the preventive medicine officers are liaisons to
11 the Board also, there was a new directive from the
12 Secretary of Defense to health affairs and the
13 Defense Research and Engineering Director that
14 tasked them to put together an expert panel to
15 review the whole military vaccine research
16 development and acquisition. And I think we ought
17 to focus on the acquisition once things are
18 developed and the availability of making those
19 vaccines. That -- they have asked for the AFEB --
20 the Executive Secretary to be there as a liaison in
21 case there are questions because we have addressed
22 so many of those issues before. The same with the
23 IOM committee. That is the reason I go to that.
24 So it is up to the Board.

25 What I think the issue is, just to sort

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1 of summarize, is there is no vaccine. We are having
2 outbreaks. The impact is more medical than
3 operational at this point because the recycling
4 criteria has really changed and many of the
5 patients are still graduating with their cohorts
6 that they entered with. So it is -- how to gain
7 momentum and at the same time there is this \$14
8 million that has been turned over to the
9 acquisition side of the house at Medical Research
10 and Development and Acquisitions Command and they
11 are ready to let a proposal on the street. And the
12 gist is that \$14 million isn't going to be enough,
13 but they are ready to get a proposal. It is viewed
14 by Medical Research and Development Command as an
15 acquisition issue at this point and not a
16 development issue of a new vaccine.

17 DR. LAFORCE: What I was going to
18 propose is that we do the same thing here that we
19 did in terms of our concerns with the criticisms
20 for the Anthrax vaccine policy. And it would really
21 be a letter to the Secretary from the Board.

22 COL. DINIEGA: I think we should.

23 DR. LAFORCE: And the letter from the
24 Secretary of the Board -- I personally am very
25 worried about the magnitude of the outbreaks when a

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1 quarter of the cases have demonstrable changes on
2 chest x-ray. Somebody is going to die and again it
3 is so statistically possible for this to happen.
4 Just literally, the more you add to it, the more
5 one is going to fall off at the tip end of that
6 bell-shaped curve. And that is the nature of the --
7 and the letter that I propose I would like to draft
8 has got to have that in it.

9 DR. ALEXANDER: Yes, exactly.

10 DR. LAFORCE: In terms of if they are
11 not listening to either the epidemiology or the
12 stuff, somebody has to at least again underscore
13 the point that they are taking a significant risk
14 of being really called to task in terms of
15 visibility or death.

16 DR. ALEXANDER: That is a wonderful
17 thing to do.

18 DR. ENGLER: That is crucial. If you put
19 that in, then those of us who have been trying to
20 help lobby or advocate or whatever have something
21 from an expert panel that is independent. But you
22 have to really lay out the implications of an
23 operational sudden effect. If you can say that and
24 extrapolate a bit, that would allow people to go to
25 each of their services and beyond and say, look,

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1 you can look really bad if you don't listen to
2 this.

3 DR. ALEXANDER: That is exactly right.
4 And by putting that in writing, what happens is
5 that if in the unfortunate situation there is a
6 death, that letter -- that file copy of that letter
7 is just phenomenal fodder for a Congressional
8 hearing. And at that point, the situation is
9 resolved.

10 DR. LAFORCE: Well, wait a second, I am
11 not too crazy about a Congressional hearing.

12 DR. ALEXANDER: No, that is absolutely
13 true.

14 DR. LAFORCE: All I want is for this
15 disease to go away.

16 DR. OSTROFF: I told you so's don't do
17 much for --

18 DR. LAFORCE: No, not for the kid that
19 is dead.

20 DR. ALEXANDER: Not for the kid that is
21 dead but sort of putting people on notice.

22 DR. ALEXANDER: That is absolutely
23 right.

24 DR. LAFORCE: The point is to make them
25 aware of that potential and that if they do have to

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1 ramp up their training, it will have a much more
2 substantial impact than it is currently having. I
3 think those are the two points that need to be
4 made. You might not be seeing it right now in terms
5 of impact and in terms of recycling, but the
6 potential is certainly there.

7 DR. LAFORCE: Okay, we have got a lot of
8 suggestions to start.

9 DR. GARDNER: What has happened since
10 1998 is you've ran out of vaccines and you've got
11 epidemics. And you've never addressed that and I
12 think you need to address that.

13 DR. LAFORCE: Julian?

14 DR. HAYWOOD: Last night, we discussed
15 briefly some alternatives for how to acquire
16 vaccine. Do you think it is reasonable to put any
17 of that in the letter, Dr. Music?

18 DR. MUSIC: I think that would be
19 appropriate if you are comfortable talking about
20 different ways of acquiring vaccines.

21 DR. LAFORCE: The IOM -- I mean, that is
22 one of the things -- as I said, with the IOM, the
23 adenovirus story, I am so committed to this. That
24 is a case study and it is going to be the case
25 study which is going to say this is -- we are so

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1 screwed up that we can't figure out how to partner
2 a private sector partnership with a public sector
3 partnership to get this done. I just -- it is sort
4 of -- and we are talking about enzymes for crying
5 out loud. You know, we are cleaning all the -- and
6 I am saying, where the hell are we?

7 DR. ALEXANDER: Right.

8 DR. LAFORCE: Okay. I will draft this
9 and I will try to get this around within a week or
10 so. This -- I am going to -- I would really
11 suggest if you could please give it some time --
12 and particularly you. You -- Steve does a lot of
13 this stuff as do you, Linda. If you could look at
14 this. I don't want an epistle to the Indians.

15 DR. ALEXANDER: Right.

16 DR. LAFORCE: But I do want something
17 that is pretty focused and that is hopefully a one-
18 pager but no more than a one-and-a-half pager, in
19 order to guarantee or hopefully guarantee at least
20 it gets read. Yes?

21 LTC NEVILLE: One last comment. The
22 line 06 commander at Lackland told me that -- in a
23 hallway conversation -- that somebody is going to
24 die, is that right, doc? The statistics show that.
25 And somebody is going to die from a preventable

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1 disease. That was the main thing -- somebody is
2 going to die was important, but that it was
3 preventable was the main thing that boiled his
4 blood.

5 DR. ALEXANDER: He got it.

6 LTC NEVILLE: He got the picture. But he
7 is an 06. He was as committed as I am to try to
8 push this letter up through the line chain. But he
9 is gone now. The fact that it is preventable is
10 important.

11 COL. DINIEGA: Do we know the case
12 fatality rate prior to the vaccine, Joel? Is that
13 all?

14 DR. GAYDOS: No. There were very few
15 deaths. In fact, all the deaths that we know that
16 have been associated with adenovirus have been
17 reported in the literature and they are in that
18 package.

19 DR. LAFORCE: There are three, aren't
20 there, that I know of?

21 DR. GAYDOS: I think there were five.

22 DR. LAFORCE: Okay. But it is something
23 like that.

24 CDR LUDWIG: The other big point,
25 though, is the base closure. A training base may

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1 have to close because of this disease. That is a
2 huge impact also. Not like somebody dying, but it
3 is going to get somebody's attention if there may
4 be a base closure because so many people are ill.

5 DR. LAFORCE: The other thing that I
6 spoke to Ben about is what I would like to do is
7 draft this note. And what we have as a strategy
8 over the next month or couple of months is to try
9 to get an appointment with the Surgeon's General,
10 one after another. And what I would like to do is
11 have a folder for each visit and that folder would
12 have the adenovirus letter. You probably only have
13 one thing to talk about, and I really don't want to
14 get wound up with chlamydia. But what I do want to
15 talk to the Surgeon's General in terms of not only
16 just sort of shmoozing and saying, hello, this is
17 what it is all about, et cetera, but there is one
18 issue that is really of huge concern as far as the
19 AFEB. And if I could just leave you this copy of
20 this letter, et cetera. That we would like to do
21 hopefully over the next month or six weeks.

22 DR. ALEXANDER: Good idea.

23 DR. LAFORCE: As a two-tiered strategy.
24 One, getting a document out and about and then
25 secondly trying to follow it up with personal

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1 visits at least at that level.

2 DR. GARDNER: I don't know how much of
3 the data you have seen from this year, but there
4 have been outbreaks on almost every single recruit
5 base in all services.

6 DR. LAFORCE: Correct.

7 DR. GARDNER: Up to 20 percent
8 hospitalizations.

9 DR. LAFORCE: Right.

10 DR. GARDNER: Up to 50 to 60 percent
11 infection rates. And up to 40 to 50 percent
12 outpatient visits and up to 60 to 70 percent
13 infection rates. I mean, this is just so
14 ubiquitous.

15 UNIDENTIFIED SPEAKER: Ted Woodward
16 might help you. It seems to me you would want to
17 revisit briefly the reasons why the original
18 vaccine was developed. There were some deaths, high
19 morbidity and Ted could -- we still don't have a
20 therapy and we will have thus. And then another
21 question or comment would be would we link this in
22 any way -- it seems to me the morbidity and
23 mortality that we are dealing with from respiratory
24 disease is the leading -- would we link this in any
25 way to influenza and the importance of preparedness

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1 in influenza. I think that is an attention getter
2 and I would try to put those two together as the
3 immunologic approaches to prevention of things that
4 certainly will result in mortality if they hit.

5 DR. LAFORCE: Other points? Yes, Joel?

6 DR. GAYDOS: I had a point that was
7 brought up yesterday which I think is important.
8 The military training camps have been used as a
9 place where all these people came together and
10 these pathogens were spread from person to person
11 and then overflowed into the community. An example
12 was meningococcal disease at Fort Worth and Fort
13 Worth was forced to close. Dr. Gray presented
14 yesterday the concern that there was spillover of
15 adenovirus Type 7 from Great Lakes into the
16 civilian community. We do know that the adenovirus
17 goes off the installation. And certainly
18 adenoviruses are a major problem in our
19 immunocompromised population, which is very large
20 in this country. And I think that the situation as
21 far as the military being the source of morbidity
22 and mortality in the civilian population is
23 something that should be avoided also.

24 DR. LAFORCE: Okay. Fair enough. I will
25 move for some satisfaction. Are there any -- I

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1 want to spend a minute or two also exploring what
2 Stan brought up in discussions that --

3 COL. DINIEGA: Are we in Executive
4 Session?

5 DR. LAFORCE: I am sorry.

6 COL. DINIEGA: I have managed to
7 continue directly --

8 DR. LAFORCE: What have I -- have I done
9 something wrong?

10 COL. DINIEGA: No, no. I just wanted to
11 know if we have gotten the work done for the
12 subcommittee.

13 DR. LAFORCE: The subcommittee work I
14 think is done.

15 DR. OSTROFF: The only other question
16 that I would raise is whether anything more needs
17 to be said vis-a-vis the influenza vaccine
18 situation. Because it is clear that the various
19 services are taking different approaches, i.e.,
20 what the Marines are doing in terms of
21 prioritizing.

22 CAPT SCHOR: That will be a Naval -- we
23 just have to put our feedback in through the Navy.
24 It is likely to be a minority opinion. It probably
25 is. I don't know how that will sort out. There

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1 will probably be just one DoD approach.

2 COL. DINIEGA: There is a DoD policy on
3 prioritization that is currently being set up by
4 health affairs to all of the services.

5 CDR LUDWIG: The signatures are due back
6 this Friday.

7 COL. DINIEGA: Right. And then the plan
8 was when the comments come in, they will be
9 incorporated as felt appropriate by the group that
10 drafted the --

11 DR. LAFORCE: You see, that is a good
12 point in that no specific question was addressed to
13 the Board in terms of influenza vaccine. We know
14 on the basis of the presentations that there are
15 likely major differences in terms of how vaccines
16 are going to be distributed. Obviously it is going
17 to be a lot different as far as the Marines are
18 concerned versus the U.S. Army.

19 CAPT SCHOR: No, sir. No, that is
20 incorrect. It is central decision making on this.
21 That is the way it will be.

22 DR. LAFORCE: There will be a single
23 policy?

24 CAPT SCHOR: Yes.

25 DR. LAFORCE: It will not be service

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1 specific?

2 CAPT SCHOR: Correct.

3 DR. LAFORCE: Fine.

4 COL. DINIEGA: Dod, you know, has
5 decided to come up with a DoD policy. And it was
6 agreed upon within the JPMPWG, the Joint Preventive
7 Medicine Policy Working Group, to do that. And as
8 it is staffed, when a difference of opinion occurs,
9 they are allowed to have their say and usually the
10 majority rules. Or the Secretary -- the Health
11 Affairs Secretary rules.

12 DR. LAFORCE: I would say that as
13 President of the AFEB, I am actually a bit
14 chagrined that no input was asked from the AFEB.
15 And it is not necessarily in terms of a codifying
16 statement, but certainly participation in the
17 discussions would have been all that would have
18 been requested. It could have been Pierce or it
19 could have been Steve or myself or anyone from the
20 Board. And I would have thought that would have
21 been sort of something pretty basic and something
22 pretty reasonable. I mean, there is a lot of
23 expertise amongst the group. I mean, that is why
24 we all have gray hair.

25 CDR LUDWIG: May I just offer, in our

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1 discussions that took place, we had frequent
2 discussions and it was more or less an emergency
3 basis. I mean, we worked on this the same way that
4 I am sure that CDC and others. And the executives
5 -- I mean, Colonel Diniega was there.

6 COL. DINIEGA: I'll take the hit. I
7 mean, I --

8 DR. LAFORCE: All it would have taken is
9 one phone call.

10 CAPT SCHOR: Some of us wanted that to
11 happen.

12 DR. LAFORCE: And that one phone call --
13 that is all I am saying. If this sort of comes up
14 again -- again, it is not a question of dictating.
15 It is not a question of saying this, this, this and
16 this. It is just a question of trying to help and
17 to be involved. Because it is important to us. If
18 it is important enough to discuss a lot of this
19 stuff, it sure in the heck is important enough to
20 discuss something -- and also because of its
21 importance as a public health problem, there is
22 actually a fair amount of competence. I mean, I am
23 talking about pretty senior competence within that
24 arena. That is all.

25 DR. BERG: I have two points building on

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1 that. One, it seems to me that all of the people
2 around here wearing the uniform kind of have an
3 obligation to represent the Board and offer it up
4 in situations like this. It is a two-way
5 communication. And I conceive of this in the sense
6 that you work for the Board also.

7 The other thing that I do not remember
8 when I was in the Navy is this proliferation of
9 groups such as the one that you are on on sexual
10 transmission. I wonder if we could get some sort of
11 presentation or listing of all these groups, who
12 they are and what they do.

13 COL. DINIEGA: I may as well say it
14 here, there are a multitude of work groups that are
15 looking at prevention arenas, and there is an
16 effort, as we heard from Lynn Pollin in a previous
17 meeting, to have this umbrella committee, the
18 Prevention Safety and Health Promotion Council, to
19 be the arena through which a lot of these verified
20 and formalized groups work through. And as a
21 result, the Injury and Occupational Illness
22 Prevention Committee is a part of the PSHPC, and
23 they have already presented their action plan to us
24 for us to review and we have made recommendations.
25 So the STD --

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1 DR. BERG: When you say us, you mean the
2 AFEB?

3 COL. DINIEGA: The AFEB. The STD
4 Prevention Committee, of which Commander Ludwig is
5 a member and they have asked me to be a member --
6 and the reason they asked the Executive Secretary
7 for the AFEB is because of the FACA rules. If they
8 named one of you as a member to represent the AFEB,
9 it would then become a federal advisory committee.

10 However, I was told by a committee man, if they
11 named the Executive Secretary as the committee
12 member, then whoever accompanies me is okay. It
13 doesn't turn into a federal advisory committee.

14 DR. ALEXANDER: I have been --

15 COL. DINIEGA: Right. And Dr. Alexander
16 is a member of the STD Prevention Committee. And
17 that group will present at our next meeting. And
18 they are working on an action plan. So the AFEB
19 will get to see that. There are several other
20 groups that will present. The Suicide Prevention
21 Committee, which is not yet under the PSHPC but
22 will be soon -- probably at the next quarterly
23 meeting. And then the Put Prevention Into Practice
24 Employmentation Committee is a formal committee of
25 the PSHPC. And they will present at the next

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1 meeting also. The Ergonomics Work Group belongs to
2 a different Secretary, and we have already opened
3 up the dialogue with them. There is a proliferation
4 of groups, but the PSHPC is beginning to scavenge
5 and survey what is going on there and try to bring
6 under the umbrella the main things. There is
7 another group that Captain Schor and I are very
8 interested in, and it is the Abuse by Military
9 Personnel of Herbal Supplements. And that group is
10 trying to get themselves together to get the
11 military specific information to be able to present
12 the problem to the PSHPC more formally, so that
13 they can get a charter and really work and fund
14 that.

15 So there are a multitude of committees.
16 Sue Baker used to go to the Injury and
17 Occupational Illness Prevention Committee. So I am
18 looking for volunteers who would like to go. We
19 fund the official reporting to these.

20 DR. BERG: I would just like a list of
21 the groups and what the acronyms are and what their
22 charters are, just to sort of keep me up to date.

23 UNKNOWN SPEAKER: If you are looking for
24 six or seven new members, the acronyms --

25 DR. LAFORCE: You know what I think we

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1 should do is at the next meeting -- that is going
2 to be an item for discussion. We will just sort of
3 set aside some time and then get -- because during
4 the course of the discussions, particularly if
5 there are two ore three committee activities that
6 are of real interest to the AFEB, we can go back
7 and then identify. If individuals are interested,
8 by heavens -- it just makes -- it enriches the
9 activity such that it is just not every three
10 months and then hello/good-bye. It really is a
11 commitment that the Board has to not only the
12 military but to general public health.

13 COL. DINIEGA: But the difficulty I have
14 encountered is that for the most part most members
15 of the Board between meetings have very limited
16 time.

17 DR. LANDRIGEN: Ben, do you have a
18 counterpart over there? What I am leading up to --

19 COL. DINIEGA: For those committees?

20 DR. LANDRIGEN: For the PSHPC.

21 COL. DINIEGA: Not a counterpart. There
22 is a coordinator at Health Affairs that coordinates
23 --

24 DR. LANDRIGEN: I am wondering if that
25 person could be invited to come here.

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1 COL. DINIEGA: That person did speak at
2 the last meeting.

3 DR. LANDRIGEN: Regularly is what I am
4 thinking of.

5 DR. OSTROFF: Can I make at least one
6 request in relation to the influenza? Just that at
7 the next meeting, which would be sometime in
8 February and we will obviously see the impact of
9 whatever the policy is going to be, if the
10 preventive medicine updates can include the flu
11 situation.

12 DR. LAFORCE: Hopefully the quiet flu
13 situation.

14 DR. BERG: The issue of the different
15 services distributing the flu vaccine in different
16 ways seems to have been settled. There is going to
17 be a uniform policy. But we also discussed a
18 little bit about the possible use of anti-viral
19 medicine. Is that something that anyone wants to
20 bring up?

21 DR. LAFORCE: Or at least the
22 stockpiling. The stockpiling. And this is where
23 the discussions at the committee level could be.
24 Because some of us have a fair amount of experience
25 within those. And during the discussions I had with

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1 Ken yesterday and also with Ben at my place last
2 night -- again, the whole issue wasn't you ought
3 to. But the idea was, gee maybe if you get a
4 little bit more information and you actually look
5 at the toxicities or the lack of toxicities,
6 particularly with the newer agents, it may broaden
7 and make easier control mechanisms for flu rather
8 than just a single vaccine related strategy. That
9 was all. It was just a way of passing new
10 information on that you may want to take advantage
11 of. That is all. It was no more than that.

12 DR. OSTROFF: And it may well be that if
13 the policy comes out that they are going to
14 prioritize retirees or the high risk individuals,
15 that that may actually impact the willingness of
16 the different services to possibly stockpile
17 antivirals for use for their front line troops.

18 DR. LAFORCE: Yes?

19 DR. ENGLER: I just would like to echo
20 what you said about flu. As an immunology
21 consultant, I was only privy to an e-mail
22 discussion, which I don't know where it went, but
23 it was with PM folks on board. And I raised a
24 number of concerns. Because again, the preventive
25 medicine view of the world is an important view of

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1 the world, but it is not the only view of the
2 world. And there is not adequate clinical problem
3 representation. And the policies that come out from
4 the policy perspective or the people who generate
5 them are, oh well, it is done. We then sit there
6 trying to actually figure out what it means. And
7 when I raise the issue of we don't know what we are
8 getting -- some of us -- what I was told from the
9 depot is whoever has their order in first will get
10 their vaccine. And so if that is true, what is the
11 ethical consideration that if Joe Shmo got his
12 order in late or that sort of thing -- that is what
13 I was sent on e-mail. I am just telling you. And I
14 said how can we market the military healthcare
15 system with the words we are just giving it to the
16 readiness force first and then we are going to
17 abandon everybody else. I would suggest that the
18 public who thinks we are here to protect them and
19 to be there for will look at some little old lady
20 with heart disease and lung disease or some little
21 guy in the trenches will interpret that policy of
22 we only have to immunize the military because we
23 ran out. That is tough. Go elsewhere. What
24 obligation do we have to create connectivity to
25 other sources? How are we going to help the

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1 totally under-researched clinical side of the house
2 manage the potential fog. I am praying and we are
3 all praying very hard that this is a quiet flu
4 season and that those viruses aren't real
5 malignant. But there is no discussion. It is like,
6 here is the policy and here is your thing and you
7 should be happy.

8 LTC NEVILLE: All of those things were
9 discussed.

10 DR. ENGLER: What?

11 LTC NEVILLE: All of those things were
12 discussed.

13 DR. ENGLER: But I would ask you -- I
14 asked the ID consultant if he was involved. I
15 asked if the people who are concerned about immuno-
16 compromised patients were involved. I don't think
17 so. I was pretty much told by e-mail it is the
18 soldier first and any concerns you have about
19 patients and issues, well that is just secondary
20 and not our problem.

21 LTC NEVILLE: That didn't come through.

22 DR. ENGLER: I understand. But what I am
23 telling you is the frustration. I want to tell the
24 Board that there is a whole group in the clinical
25 community that is as frustrated as you are.

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1 Because it is not a balanced discussion. It is not
2 a health to the trenches. The policies are
3 frequently very hard to dissect. And if you think
4 it is going to be uniformly applied, you are living
5 in a delusional world. Because it won't. Because
6 I'll bet you the understanding of the trench
7 workers will be, well this must mean active duty.
8 How do we handle -- is asthma
9 -- you know, there is asthma. The Academy of
10 Allergy and Immunology is recommending flu for
11 asthma. Where do the pregnant women come in? I
12 mean, it is really bad that we are in a year where
13 we have expanded the recommendation for the flu.
14 When they just say high risk and military
15 operational, well within the high risk let's think
16 the worst, that the company fails. How do we
17 stratify within there?

18 CDR LUDWIG: We did stratify high risk.
19 And we basically followed the CDC recommendations
20 on those things.

21 DR. ENGLER: Well, even though --

22 CDR LUDWIG: We can't do anything but
23 offer a policy. That is all we are empowered to do.

24 DR. ENGLER: I understand. The draft I
25 have seen leaves some room for --

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1 CDR LUDWIG: It was old. That was old.

2 DR. LAFORCE: Okay. Next are discussion
3 items.

4 COL. DINIEGA: We are done with the
5 comments on anything that was presented, right?

6 DR. LAFORCE: Yes, pretty much.

7 COL. DINIEGA: Okay. I don't think we
8 need to say anything more about Anthrax at this
9 point. I do have -- may I?

10 DR. LAFORCE: Yes, sir.

11 COL. DINIEGA: A couple of updates. At
12 the last meeting, the whole issue of the BW threats
13 from the Joint Chiefs was discussed extensively as
14 we all remember. And the NBC operations office at
15 that point had promised regular updates on the
16 medical risk analysis to the Board. And I said just
17 give me something and I will pass it on to the
18 Board. They want the Board to know that they have
19 contracted for someone to help with the medical
20 risk analysis. What they are looking at is setting
21 up work groups to take a look at the criteria for
22 doing the medical risk analysis. They want it in
23 black and white. There is an oversight group that
24 they want somebody from the AFEB to be on.

25 DR. LAFORCE: Good.

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1 COL. DINIEGA: And so they are putting
2 me down as Executive Secretary. So I will need
3 somebody to do that with me. And then the other
4 issue is that I asked personally to be on one of
5 the work groups. So I probably will be on the work
6 group, not so much representing the AFEB, but
7 always doing that anyway. But making sure that
8 since this is considered -- the medical risk
9 analysis I consider one of the things we have been
10 trying to work for for many years now in this
11 arena, I just want to make sure that the work
12 groups are on the right track.

13 There were four recommendations from the
14 last meeting. The squalene paper you heard from
15 Lieutenant Riddle. They haven't heard back from
16 Congress on any of the things. The other was the
17 Ergonomic Work Group Plan, which we have talked
18 about, and then the BW threat review, which there
19 are no new threats.

20 But the other significant recommendation
21 that came from the Board was the antibiotics that
22 could be useful against biowarfare agents. That
23 went over to Health Affairs. They reviewed it.
24 Colonel Takafuji is now gone and somebody else is
25 going to inherit that. But that is going to help

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1 them quite a bit in looking at things that would be
2 useful. Stockpiling is a very sensitive issue now
3 with everybody. Because if it is not FDA approved,
4 then why are you stockpiling it.

5 DR. OSTROFF: There is one change in the
6 letter that was put together. That is that Cipro
7 is now approved. And I think it is just approved
8 for treatment. It is not approved --

9 DR. LAFORCE: No it is approved for
10 prophylaxis.

11 DR. OSTROFF: For prophylaxis as well?

12 DR. LAFORCE: Yes, that is a prophylaxis
13 approval.

14 COL. DINIEGA: Yes.

15 DR. LAFORCE: That was a huge --

16 COL. DINIEGA: That was very big.

17 DR. BERG: Was it approved for
18 prophylaxis or prophylaxis after exposure.

19 DR. LAFORCE: That is it.

20 COL. DINIEGA: Post-exposure
21 prophylaxis. And Anthrax. And I think not in kids.
22 And that is on the Board recommendations. So I am
23 sure whoever is going to take Colonel Takafuji's
24 place is going to inherit that.

25 MAJ BALOUGH: Sir, can I say something

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1 on that?

2 COL. DINIEGA: Sure.

3 MAJ BALOUGH: The service came back with
4 quantities and that was sent out to different
5 CINCS. And CENTCOM has come back and said that is
6 enough. They have got what they needed.

7 COL. DINIEGA: As far as what?

8 MAJ BALOUGH: The antibiotics.

9 COL. DINIEGA: Oh, antibiotics against
10 the BW agents?

11 MAJ BALOUGH: Right. They said they have
12 -- that is sufficient for what they've got or what
13 they need. We are still waiting for PACOM to come
14 back.

15 DR. BERG: When you say that is
16 sufficient, you mean they have got enough supplies
17 on hand?

18 MAJ BALOUGH: For what they feel they
19 need.

20 DR. BERG: For what they feel that they
21 need.

22 COL. DINIEGA: In June, the preventive
23 medicine officers met to select new members to the
24 Board. There are six new members that are in the
25 appointive process. They are Environmental and

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1 Occupational Health, Dr. Dennis Shanahan.

2 DR. BERG: Did you say where he is
3 coming from?

4 COL. DINIEGA: Shanahan is ex-military
5 who is aerospace medicine and his expertise is in
6 injuries. Carl Zwerling, for those of you who know,
7 declined because of previous commitments to the IOM
8 and CDC committees. That is the competition for
9 appointments. Doug Campbell, occupational medicine
10 position, North Carolina Health Department and now
11 in private practice was nominated by Stan. And he
12 accepted the appointment to the Board. And then the
13 first alternate was John Herbold, who was
14 previously at Health Affairs, and his name came up
15 with the HIV-AIDS thing in the middle. He was a
16 program analyst at Health Affairs. But he is a vet
17 who has been involved in environmental health quite
18 a bit and infectious diseases. He was the first
19 alternate. So when Zwerling turned it down, we went
20 to him and he has accepted. So Shanahan, Campbell
21 and Herbold.

22 DR. BERG: Campbell is ex-EIS?

23 COL. DINIEGA: Yes, he is ex-EIS and ex-
24 Marine. For Health Promotion and Maintenance,
25 there were two selected. Dr. Brownson declined.

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1 Dr. Kumanyika declined. We needed two. The first
2 alternate, Dr. Patrick, who is at University of San
3 Diego --

4 DR. BERG: Kevin Patrick?

5 COL. DINIEGA: Kevin Patrick, right. He
6 accepted and will be on the Board. But we need to
7 select another person. Disease Control, Bob Shope
8 at the University of Texas at Galveston accepted.
9 Bill Moore, who is a retired infectious disease
10 physician and two-star in the Army accepted. He is
11 the State Epidemiologist in Tennessee, accepted.
12 So with the loss of Dr. Music who is on the
13 Occupational Environmental Health Committee and Dr.
14 Tsai, who is Infectious Disease, and the need for
15 one more in Health Promotion, we have to select --
16 the PM officers have to select three additional
17 members to keep the membership at 20. What
18 normally happens is that about two-thirds can show
19 up at a meeting at any one time, that is the norm.
20 So that would give us 15 members at a meeting.

21 DR. GARDNER: Has Ken Holmes ever been a
22 member of this committee?

23 COL. DINIEGA: Who?

24 DR. GARDNER: Ken Holmes in Sexually
25 Transmitted Diseases and AIDS?

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1 COL. DINIEGA: I don't think so.

2 DR. GARDNER: He would probably like to
3 do it.

4 COL. DINIEGA: There were a total of six
5 left over from the year before and 11 new
6 submissions for this year. We need more
7 recommendations. What is needed is, one, an updated
8 CV, a letter of recommendation -- it can be very
9 short, an e-mail type from whoever is doing the
10 nominations on why they think the person would be a
11 good fit. If it comes from somebody in active
12 duty, the nomination does, then it has to go to the
13 service preventive medicine officer who is the
14 liaison to the Board, just to make sure that they
15 know about it and they agree. Because they will
16 have to be looking at the nominations. And whoever
17 nominates, please explain the Board. If you need
18 help from me, I will do that. But explain to
19 whoever you are nominating what the Board is about
20 at least and what the time commitment is. What we
21 don't want is people who we never see at meetings.

22 That is the main thing. The appointment is two
23 years. The PM officers ask that reappointments not
24 be automatic and it be run by them first. And I
25 usually talk to Dr. LaForce too. The main concern

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1 is how active were they with the Board. Because I
2 am sure the credentials are good. But it is a
3 matter of how active they are with the Board. So it
4 is a two-year term, maximum of four years. So two
5 two-year terms. Any questions on that? The
6 appointment process -- they should be ready for the
7 next Board meeting. Now unlike the last February
8 meeting, their appointments came through a day or
9 two after our meeting. We had all the orders ready
10 to go before then. Hopefully this time we have
11 more lead time. Part of the appointment packet now
12 for approval for appointment is the OGE-450, which
13 is the financial disclosure statement. That will be
14 a requirement for the appointment packet to go
15 forward. And the legal office will review. The
16 concern is only who the employer is. That is the
17 main concern.

18 Since I am talking about the OGE-450's,
19 that will be an annual requirement for all Board
20 members. So it will be a requirement for the
21 appointment packet and it will be an annual
22 requirement. The other big requirement for Board
23 members, as you all know, is the security
24 clearance. You have to be cleared for a security
25 clearance up to secret, and that usually entails a

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1 lot of answering of questions like where were you
2 the last 10 years and all your employers and all
3 your residences.

4 DR. ALEXANDER: There was some kind of
5 question about my security clearance, which was
6 ironic because I had a top secret before. But
7 anyway, the woman who called, I have called -- she
8 said there is a question and I need an answer. I
9 have called her back I bet a dozen times.

10 COL. DINIEGA: Do you know who that was?
11 Jenny Ellington?

12 DR. ALEXANDER: Yes.

13 COL. DINIEGA: Okay. She has been in and
14 out of her office because of the summer. People
15 take vacation. She is there now.

16 DR. ALEXANDER: I have left her so many
17 messages.

18 COL. DINIEGA: Send me an e-mail -- do
19 it by e-mail.

20 DR. ALEXANDER: I don't have her e-mail
21 address.

22 COL. DINIEGA: I will send you her e-
23 mail address. Remind me. I will put it down here,
24 but just remind me.

25 DR. ALEXANDER: Okay.

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1 COL. DINIEGA: We are going to be down
2 in the office for probably the next two days. They
3 are painting and changing carpets. So we have to
4 pack up and move out. I have to be packed up and
5 moved out by 5:00 tomorrow. But I will put it down
6 here.

7 DR. ALEXANDER: I don't want to be
8 declared negligent when I have really been trying.

9 COL. DINIEGA: And you know, the only
10 time you need that clearance is when we do the BW
11 threat review. Now for the Gulf War illness, they
12 needed it because they had a lot of meetings about
13 what to do with the IND products and how to go
14 about using it. So the security clearances and
15 then the OGE-450's. Please fill them out. They
16 are not asking for amounts. They just want to know
17 what your holdings are. You don't have to list all
18 the stocks and bonds in your mutual fund, you just
19 name the mutual fund. But they want a listing of
20 individual stocks also. And they are not asking
21 for how much do you make. They want to know where
22 the income comes from and whatever you owe close
23 to. My name will be submitted to Health Affairs as
24 a nomination to move over to Dave Trump's position
25 as the preventive medicine officer. It was not my

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1 doing. They had asked me previously and I said
2 wait until next summer. And then when Dr. Clinton
3 took over from Dr. Sue Bailey, he went directly to
4 the Surgeon Generals and said I need somebody and I
5 need them right away. And General Peak, whom I have
6 worked for on four different occasions, put my name
7 in the ring. The high visibility was that I got
8 all kinds of e-mails from people who work for him,
9 including General Scully, who is the deputy or the
10 Acting Surgeon General now. He came and talked to
11 me about taking that position. It is hard to say
12 no.

13 So depending on how fast they want me,
14 which they want me as soon as possible -- as soon
15 as that job is firmed up, we will put out a
16 nomination for a new Executive Secretary for the
17 Board. And the process, for your information, is
18 that we ask the services to submit nominations the
19 same as the Board members. They send in their CV's
20 and their official military records and they
21 officer record briefs. And then they go over to
22 the -- and they get an endorsement from either the
23 SG's or some general officer. And if there is more
24 than one name submitted, it becomes a competitive
25 job application. Then they are all interviewed.

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1 Right now Health Operations and Policy, the Board
2 falls under that section of Health Affairs. Dr.
3 Clinton used to be and Dr. Claypole used to be the
4 head of that. Now the acting is Mr. Ron Richards,
5 who is an SES. He will select from among the
6 candidates. As soon as that occurs, then I'll be
7 able to move, unless they can make other temporary
8 coverage arrangements.

9 DR. LAFORCE: Actually from our
10 standpoint, you are going to be a huge loss.

11 COL. DINIEGA: I do want to thank the
12 Board -- all the current and previous Board members
13 and the members of the JPMPWG and all the liaison
14 officers. Because I think all the liaison officers
15 have made this job much easier to do. I bang on
16 their desks for presentations and questions and I
17 bang on their desks for feedback on the
18 recommendations. They never kick me out of any
19 meeting and they let me say what I want to say. We
20 have a very mutual agreement. And all of the PM
21 officers are really excellent. And then the Board
22 members for their participation, but especially
23 those that have taken the lead on issues, Stan
24 Music being a very good example. Stan -- you know,
25 Stan -- Dennis Parrota beforehand. Dr. Poland,

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1 Greg Polland, who wants to be a Marine still yet.
2 Steve Ostroff, who despite being the czar, manages
3 to find time to send me drafts, et cetera. And of
4 course, Dr. LaForce. Dr. LaForce and I talk at
5 least three times a week whenever he is in town. I
6 never try to find him in Africa. But when he is in
7 town, we are always talking. But, you know, I
8 wanted this job. General Peak wrote my
9 recommendation for this job. So how can I tell him
10 I won't go do what he wants me to do. And it is
11 something I always wanted to do since I first made
12 a presentation in 1982 about an outbreak of febrile
13 illness in a battalion of soldiers who went to
14 Panama to do jungle operations training center and
15 came back with fevers that we thought were malaria.
16 It turned out to be leptospirosis. That is my
17 favorite disease. My first presentation to the
18 Board was on that. Dr. Woodward remembers a lot of
19 that. He has a fabulous memory. It was just so
20 nice hearing him and seeing him again today. Ever
21 since then, that has been one of my goals is to get
22 the Executive Secretary position. It did come
23 true. I have had my shot at it and it is time to
24 move on. So I just want to thank everybody.

25 DR. LAFORCE: Your last act is to get

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1 Hickam.

2 COL. DINIEGA: We will try. That
3 reminds me, we will try. There are two ways to do
4 that. I really need the calendars of non-available
5 dates so that we can set the meeting date. We need
6 three months between meetings and we are sort of
7 stuck with the BW threat review in May. So if you
8 back it up, the meeting can't occur later than mid-
9 February. Last year we had it at the end of
10 February. We still managed to work the BW meeting.

11 So I have the people working on
12 recommendations. I have your name and I know your
13 e-mail and your phone number. And I usually do
14 business by e-mail. So I am set. Get your travel
15 settlements in. It is a little crucial this time
16 because of the end of the year. The Army goes on
17 fiscal year, so September 30th. We need to get all
18 of those travel settlements in before the end of
19 the month. Otherwise, they will have to carry over
20 for next year. And if Congress hasn't passed the
21 budget, they go with continuing resolutions. Any
22 questions of me?

23 DR. LAFORCE: Other questions or
24 statements or issues?

25 DR. HAYWOOD: I want to raise a point

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1 for the next meeting. I had hoped there would be
2 time in this Executive Session to bring up the
3 general question of the role of the Board. But I
4 would suggest that be on the agenda for the next
5 meeting. Rather than dealing with how the Board
6 operates on specific issues, its overall role in
7 the background of Dr. Woodward's presentation
8 today.

9 DR. LAFORCE: Yes. And I would also like
10 to maybe set forth what Stan brought up in terms of
11 codifying a relationship, particularly with
12 military medicine. I thought that was a terrific
13 idea. Maybe one of the things that I will do from
14 now until the next meeting is actually see about
15 working either with Ben or somebody to actually
16 meet and chat with the editor -- the senior editor.

17 Just to introduce the Board and just to sit down
18 and chat.

19 COL. DINIEGA: Just a reminder. The
20 AMSAS Military Medicine is a private organization.

21 DR. LAFORCE: Right.

22 COL. DINIEGA: The CDC MMWR is a CDC
23 publication. The Army has an equivalent of the
24 MSMR, the Medical Surveillance Monthly Report. You
25 know, AMSAS now is the Defense Medical Surveillance

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1 System or Agency or whatever they want to call it.

2 But I think they were having plans to have a
3 Defense Medical Surveillance Monthly Report of some
4 sort. So if you were to do it in parallel.

5 DR. LAFORCE: Perfect.

6 COL. DINIEGA: That would be where it
7 would be.

8 DR. GARDNER: We could have a liaison
9 member coming to these meetings. Along with Stan
10 being the liaison member from the pharmaceutical
11 industry. We need him back.

12 DR. ALEXANDER: Could we actually put
13 that on the agenda for next time? I would like
14 some discussion on the role with industry, one at
15 the personal level because I work really closely
16 with industry, yet I don't feel branded. But two,
17 I see phenomenal opportunities for us to interface
18 with industry, and there must be ways to design
19 such a relationship where you would maintain that
20 federal protection that is so desired by the Army
21 legal folks.

22 And yet at the same time have
23 opportunities for us to interface that would be
24 advantageous to us and the problems that we are
25 challenged with. So if we could put that on the

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1 agenda. It is more than a ten-minute discussion.

2 DR. HAYWOOD: With all due respect, I
3 think that is a subtopic of the broad issue.

4 DR. LAFORCE: But it would involve -- in
5 order to plan for that, we would have to make sure
6 that somebody from legal -- do you see what I mean?
7 In order for this to be a discussion, we would want
8 to have some --

9 COL. DINIEGA: Legal has offered to come
10 and talk to the Board about the conflict of
11 interest issues. Now just a reminder, there is a
12 big difference between the DoD statute and other
13 statutes on conflict of interest. And the biggest
14 difference is in many of the military statutes or
15 regulations or whatever, it has the terminology
16 "the appearance of." And that is very different
17 from the civilian sector, where it has to be yes or
18 no. The military for a lot of things -- sexual
19 misconduct, fraternization, et cetera -- has the
20 appearance of. And appearance of is not determined
21 by the people inside. It is the people outside. So
22 the minute somebody on the outside says it looks
23 like, then you are stuck.

24 DR. LAFORCE: Yes, Bob?

25 DR. BERG: Would it be possible to get a

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1 DoD lawyer to address it? Because one of the
2 things is -- I deal with our State Attorney General
3 all the time and one of the things I have learned
4 as have my fellow health directors, when you are
5 dealing with lawyers, you have to be very careful
6 how you phrase the question. Because their native
7 answer is no. So you need to ask is there a way we
8 can do this. And with the Army judge advocates
9 having already weighed in with it, I think if we
10 invite him what we are likely to get is the
11 standard conflict of interest answer.

12 COL. DINIEGA: There is one glitch to
13 that. The AFEB -- the executive agency for the
14 AFEB is the Army. And as I found out with Dr.
15 Parrota and I don't know if Stan was there, but I
16 had my hand slapped when we closed a meeting on the
17 advice of the DoD lawyer. DoD said you can close
18 the meeting. It turns out that I was supposed to go
19 to the Army lawyers and the Army lawyer's decision
20 was there was no reason for closing the meeting.

21 DR. ALEXANDER: Can we have both of
22 them?

23 COL. DINIEGA: Well, I don't want to --

24 UNIDENTIFIED SPEAKER: If there is
25 anything worse than one lawyer, it is two lawyers.

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1 COL. DINIEGA: The bottom line is the
2 Army runs -- is the administrative power.

3 DR. BERG: Apropos of distributing the
4 recommendations, all of the Surgeons Generals have
5 Websites. So that would be another good place to
6 put the recommendations from the Board.

7 COL. DINIEGA: We do have a Website. Dr.
8 Trump was handling that for us. It is
9 tricare.osd.mil/afeb. And since Dr. Trump left, we
10 haven't updated. But we plan -- right now it has a
11 little blurb on the Board, a listing of members
12 that has got to be updated. And then it has the
13 last year's recommendations -- the previous
14 recommendations aren't on there yet. We just have
15 to make the connection to get it on there.

16 DR. LAFORCE: 29 minutes after. We
17 finished a minute early.

18 COL. DINIEGA: Who is interested in the
19 WRAIR tours still yet?

20 (Whereupon, at 12:32 p.m., the meeting
21 was concluded.)

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